REVIEW OF THE

Virginia Community Services Board Emergency Services Programs

---

Prepared by:
Office of the Inspector General
For Mental Health, Mental Retardation
And Substance Abuse Services

James W. Stewart, III
Inspector General

Report: #123-05

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs

Table of Contents

Section I

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs
Executive Summary

The Office of the Inspector General (OIG) for Mental Health, Mental Retardation & Substance Abuse Services conducted a review of the statewide system of community services board (CSB) emergency services programs (ESP) during May to August 2005. This focus for the OIG's first review of licensed community programs was selected because of the critical role ESPs play in responding to citizens when they are most at risk. Over 49,000 individuals are served annually by ESPs.

To assure that the review focused on current issues, the OIG invited the contribution of ideas from a wide range of stakeholders including consumers, family members, community and facility providers and the staff of the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS). The basis for the review was nine Quality Statements for Emergency Services that were developed by the OIG (page 9 in Section II of report). The methodology for the review included the following: a survey of all 40 CSBs, unannounced telephone responsiveness tests of all 40 ESPs, and unannounced field inspections of 18 ESPs. Interviews were conducted with 246 consumers, 78 community stakeholders (sheriffs, police, hospital staff, magistrates) and 122 CSB staff.

Findings and Recommendations

The findings and recommendations from this review have been organized into two groupings – those that relate to **Access to Appropriate Services** and other findings that have an impact on **Quality of Care**.

Access to Appropriate Services

Each consumer served by an ESP presents a unique set of needs and issues. In order to provide the most effective crisis intervention to each consumer – in the least restrictive setting - an ESP must have access to a comprehensive array of crisis intervention services. The findings related to Access are based on current availability of a full array of crisis intervention services at each of the 40 CSBs. Current availability of crisis intervention services at each CSB is summarized on page 12 in Section III of the report.

Access Finding 1: The majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance use disorders. Almost all CSBs offer the least restrictive Crisis Response, Resolution and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the critical mid-range Community

Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community. As a result, many consumers are denied effective treatment in the least restrictive setting and there is greater dependence on inpatient hospital care that is the most costly treatment alternative.

Access Recommendation 1a: It is recommended that DMHMRSAS, in cooperation with the Virginia Association of Community Services Boards (VACSB), conduct a short-term study to identify and define the alternative Crisis Stabilization Services, determine which will enable CSBs to improve their ability to serve consumers least restrictively, and quantify the number and cost of each service.

Access Recommendation 1b: Based on the results of the study, it is recommended that individual CSBs and regional groupings of CSBs identify ways in which current resources may be redirected to create crisis stabilization alternatives, and DMHMRSAS request sufficient funding to enable the development of the needed Community Crisis Stabilization Services statewide.

Access Recommendation 1c: It is recommended that once projections can be made regarding the impact of the widespread availability of Community Crisis Stabilization, DMHMRSAS in collaboration with the VACSB and the Virginia Hospital and Healthcare Association determine what level of local acute psychiatric Inpatient Hospital care is needed and develop strategies to address any unmet need.

Access Recommendation 1d: It is recommended that DMHMRSAS develop consistent expectations for all state hospitals regarding 1) admission of consumers when acute beds are not available in local community hospitals and 2) admissions procedures during weekday, evening and weekend hours.

Access Finding 2: While the majority of CSBs offer the less intensive Crisis Response, Resolution and Referral Services, capacity limitations significantly restrict service effectiveness, especially in rural areas.

Access Recommendation 2a: It is recommended that DMHMRSAS lead an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. This will result in maximizing the effectiveness of physicians who are already in the public provider system and will enhance the continuity and quality of care provided in facilities and in the community.

Access Recommendation 2b: It is recommended that each CSB routinely monitor the length of time required for consumers to gain telephone and face-to-face access to an ESP clinician and make adjustments to improve response time.

Access Recommendation 2c: It is recommended that DMHMRSAS request funding to enable CSBs to expand capacity and fill gaps in Crisis Response, Resolution, and Referral Services.

Access Finding 3: Most communities do not have access to appropriate crisis intervention for consumers with mental retardation. In addition, the role of state hospitals and training centers in serving these persons is not clear. As a result: 1) consumers and staff are placed in dangerous situations and 2) consumers are referred to services that are not appropriate.

Access Recommendation 3a: It is recommended that DMHMRSAS conduct a study to: 1) identify and define the continuum of crisis intervention services for persons with mental retardation, 2) determine which of these services if made available widely throughout the state would enable CSBs to improve their ability to serve consumers with mental retardation who are in crisis, and 3) quantify the number and cost of each type of service that is needed. Based on the results of the study, it is recommended that DMHMRSAS propose solutions and request sufficient funding to enable the development of the needed crisis intervention services for persons with mental retardation.

Access Recommendation 3b: It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not, and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

Access Finding 4: Non-Emergency Support and Clinical Services provided in the community (PACT, residential, medication, etc.) do not have adequate capacity. As a result, ESPs deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services.

Access Recommendation 4: In order to prevent crises and lessen demand on the emergency services system, it is recommended that DMHMRSAS and Department of Medical Assistance Services (DMAS) work cooperatively to steadily increase the capacity of the community services system to provide non-emergency support and clinical services

Access Finding 5: Current practices at public and private hospitals require "medical clearance" to rule out non-psychiatric explanations for behavioral symptoms and to assess the presence of medical conditions that may exceed the treatment capabilities of the psychiatric facilities. The delays, costs, legality, and inconsistency among hospitals regarding medical clearance are a major source of concern among stakeholders, hospital medical emergency rooms, and consumers.

Access Recommendation 5a: It is recommended that the Code of Virginia be amended to clarify that medical screening is an authorized activity under Temporary Detention Order (TDO) procedures.

Access Recommendation 5b: It is recommended that DMHMRSAS develop and implement clear and consistent standards regarding medical clearance for all state hospitals and work with the Virginia Hospital and Health Care Association and other appropriate bodies to achieve a similar outcome for private hospitals.

Quality of Care

Quality of Care Finding 1: Virginia's CSB system of emergency services is staffed with well qualified, experienced, highly motivated, and well-supervised staff. Staff knowledge of the adult

mental health population is stronger than it is for other consumers groups. Training for ESP staff is limited. The certification system for emergency prescreeners needs to be updated.

> **Quality of Care Recommendation 1a:** It is recommended that DMHMRSAS, with the assistance of CSBs, update and clarify requirements for certification of CSB pre-screeners.
>
> **Quality of Care Recommendation 1b:** It is recommended that DMHMRSAS and CSBs collaborate in developing and sponsoring regular training regarding a wide range of topics related to crisis intervention services including intervention with special populations.

Quality of Care Finding 2: CSB ESPs are sensitive to the importance of providing for the safety and privacy of consumers who are served in crisis. Few provide mobile emergency services in the locations most preferred by consumers – their own homes or in the community.

> **Quality of Care Recommendation 2a:** It is recommended that 1) CSBs work actively to increase the use of mobile emergency services, seeing consumers in their home and community and 2) CSBs and local law enforcement agencies work together to increase their collaboration for the purpose of assuring safety for mobile crisis intervention staff.
>
> **Quality of Care Recommendation 2b:** It is recommended that CSBs and local law enforcement agencies make every effort to assure that crisis intervention services are provided in settings that are comfortable for consumers and decrease stigmatization.
>
> **Quality of Care Recommendation 2c:** It is recommended that statewide sheriff, police and CSB associations work collaboratively to develop guidelines for safe and non-stigmatizing transportation of consumers in the civil commitment processes.

Quality of Care Finding 3: All CSBs that were visited by the OIG have mission statements, and staff are generally familiar with the direction set for the organization. A number of CSBs do not have clearly stated operational values or guiding principles. The majority of staff are not familiar with the recovery model which is a major component of the System vision statement recently adopted by DMHMRSAS.

> **Quality of Care Recommendation 3a:** It is recommended that each CSB 1) review its mission statement and make any needed changes to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS and 2) review strategic objectives and initiatives to assure consistency with the revised mission statement.
>
> **Quality of Care Recommendation 3b:** It is recommended that each CSB develop a clearly stated set of values or principles that are consistent with the system vision statement. Once these statements are established, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the CSB reflect the values or principle statements.
>
> **Quality of Care Recommendation 3c:** It is recommended that DMHMRSAS, in conjunction with a representative group of CSB staff, state mental health facility staff and consumers, develop a training curriculum that is competency based regarding the principles of recovery. Once the curriculum is completed, training should be made available to CSBs, state facilities and licensed private providers.

Quality of Care Finding 4: CSB emergency services decisions regarding whether to detain or release consumers in crisis are consistently competent. These decisions are well documented and the documentation supported the clinical decision. These practices were consistent across the state.

> **Quality of Care Recommendation 4**: It is recommended that DMHMRSAS with the assistance of CSBs and private hospitals, revise and update the Uniform Pre-Admission Screening Form and make it available in electronic form.

Quality of Care Finding 5: Few CSBs report formal systems to monitor and improve effectiveness and quality of their emergency services. Nevertheless, feedback to the OIG by consumers and stakeholders revealed general satisfaction with the services.

> **Quality of Care Recommendation 5:** It is recommended that each CSB develop a process for routinely seeking evaluative comments from consumers, families and community providers regarding the quality of services provided by the CSB programs and the effectiveness of the CSB's relationship with the broader provider service system.

Quality of Care Finding 6: ESP services are well coordinated with other CSB services for consumers, with generally good communication across programs.

> **Quality of Care Recommendation 6a**: It is recommended that CSBs work with consumers to develop advance directives or crisis plans to identify consumer and family preferences, resources and requests that should be honored if the consumer experiences a crisis.
>
> **Quality of Care Recommendation 6b:** It is recommended that CSBs, with the assistance of DMHMRSAS, develop electronic record systems that are accessible to ESPs around the clock.

Quality of Care Finding 7: Each ESP has a well developed policy and procedure manual that includes resources to assist staff in serving consumers. Clinical records reflect compliance with applicable policies and procedures.

> **No recommendations**

Section II

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs
Background of the Study

About the Office of the Inspector General

The Office of the Inspector General (OIG) is established in the VA Code § 37.2-423 to inspect, monitor and review the quality of services provided in the facilities operated by the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) and providers as defined in § 37.2-403. This definition of providers includes community services boards (CSB) and behavioral health authorities (BHA). It is the responsibility of the OIG to conduct announced and unannounced inspections of facilities and programs. Based on these inspections, policy and operational recommendations are made in order to prevent problems, abuses and deficiencies and improve the effectiveness of programs and services. Recommendations are directed to the Office of the Governor, the members of the General Assembly and the Joint Commission on Healthcare.

Selection of CSB Emergency Services Programs for Review

This review of the emergency services programs (ESPs) operated by Virginia's CSBs is the first major series of inspections of licensed community-based services conducted by the OIG. This project was selected for the following reasons:

- Emergency services, including code requirements for prescreening civil admissions to state facilities, is one of only two services specifically mandated by the Code of Virginia for provision by CSBs. The other mandated service is case management.
- Over 49,000 Virginia consumers were served by ESPs in FY2004. This is 26 per cent of the total unduplicated count of consumers served by CSBs that year.
- Emergency services deal with extraordinary situations in which grave danger to the health and safety of consumers or the community may occur.
- In providing emergency services, CSBs fulfill Va. Code provisions for civil commitment, a sensitive area for all concerned.
- Many aspects of the provision of emergency services elicit strongly expressed and divergent positions among consumers, family members, law enforcement officials, hospital personnel and other stakeholders. Some of these concerns include risk of suicide, involuntary civil admissions, transportation of consumers by law enforcement agencies, limited availability of psychiatric hospital beds, etc.
- Virginia's civil commitment legislation and attendant issues are under frequent legislative review.
- The Inspector General has received a number of suggestions and requests from a wide range of stakeholders that emergency services be studied.

Study Methodology

Input to the Design of the Study

The OIG began the process of evaluating ESPs by conducting an extensive literature search of indicators of quality in crisis intervention services, as seen by consumers, clinicians, academics, standard-setting organizations, family members, etc. In addition, input was sought from a wide variety of providers, stakeholders and consumers through a series of teleconferences and meetings in April and May 2005. Input to the design of the study was received from the following groups:

> DMHMRSAS leadership and central office staff, DMHMRSAS facility directors, state and local mental health consumer leadership groups and individuals, the Mental Health Planning Council, advocacy groups including National Association for the Mentally Ill - Virginia (VAMI) and Virginia Mental Health Association, CSBs (executive directors, mental health/substance abuse services directors, mental retardation services directors, and emergency services directors), Virginia Hospital and Healthcare Association, Department of Medical Assistance Services (DMAS).

Quality Statements for Emergency Services

The OIG developed a set of 9 Quality Statements for Emergency Services, with 44 specific quality indicators, based on an extensive literature search and input from Virginia stakeholders. The Quality Statements for Emergency Services are as follows (the 44 detailed quality indicators are found in the Appendix, Section V.A, page 31):

1. The work of the ESP is guided by a clearly stated mission statement and principles or values. These statements are understood by staff and guide their work.
2. The ESP has clearly developed policies and procedures that provide guidelines for practice. ESP practices comply with policies.
3. The ESP assures that all staff providing crisis intervention services are qualified to provide these services and there is competency training and a system for assessing competency in place to assure that all staff have the skills to meet the needs of consumers.
4. Emergency Services, including both crisis intervention and prescreening services, are available at all times and easily accessible in a timely fashion.
5. The CCSB offers an array of intervention services that address the emergency needs of the community and its citizens.
6. Crisis interventions are guided by sound clinical judgment and seek to meet consumers' needs with the least restrictive option for care, with involvement and choice for the consumer.
7. Services are provided in a manner that supports consumers in feeling safe and fosters treatment with dignity and respect. The location of emergency services provides for confidentiality, privacy, consumer comfort, and security.
8. There are systems in place to monitor and continuously improve the effectiveness of the emergency services provided, including consumer and stakeholder satisfaction.

9. Emergency services complement, support, and are well coordinated with the other services consumers' receive from the CSB.

The OIG ESP study consisted of five main components:

- An 18-item, self-administered survey, completed by each of Virginia's 40 CSBs, that describes emergency services availability, resources, and operating procedures.
- Unannounced service availability and responsiveness tests of the ESP of each of the 40 CSBs during office hours and on evenings or weekends. (Telephone response time tests were carried out by OIG staff acting as consumer surrogates.)
- Unannounced field inspections of a representative sample of 18 of the 40 CSBs by OIG staff teams (May-August 2005).
- Surveys of Virginia's state mental health facilities, evaluating the ESPs of the CSBs that refer consumers for hospital care.
- Self-administered surveys distributed to consumers and family members by consumer and family leadership groups. OIG staff conducted interviews of consumers at 18 CSBs. Consumer employees were hired to conduct consumer-to-consumer interviews in 6 communities. A total of 246 consumer surveys was received.

Inspections of CSB Emergency Services Programs

The unannounced field inspections were conducted by a team or 2 or 3 OIG inspectors and averaged 8 hours. One CSB (Fairfax-Falls Church) received an inspection that focused only on that CSB's crisis stabilization center. 17 CSBs received full inspection visits, consisting of all of the following components:

- Interviews with CSB administrative and clinical leadership: executive directors, and directors of mental health, mental retardation, child, community support, and substance abuse services.
- Interviews with CSB direct service emergency staff. Over 120 direct service and administrative staff were interviewed.
- Observations of main and secondary emergency services evaluation and service sites.
- Inspection of personnel records to assess qualifications and certifications of staff providing emergency services.
- Interviews with consumers recently served by each CSB's emergency services system, usually at psychosocial or clubhouse programs.
- Review of over 140 clinical records to assess quality and appropriateness of clinical evaluations and interventions and adequacy of documentation.
- Interviews with 78 key community stakeholders who interact regularly with emergency services: sheriffs, police departments, local hospitals, magistrates, special justices, advocates, consumer groups, family members, and other agencies.

As part of the 18 on-site inspections, OIG staff visited three crisis stabilization services now in operation in Virginia (Central Virginia CSB, Fairfax-Falls Church CSB, and Richmond Behavioral Health Authority – for the HPRIV Re-Investment collaborative).

Section III

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs
Findings and Recommendations

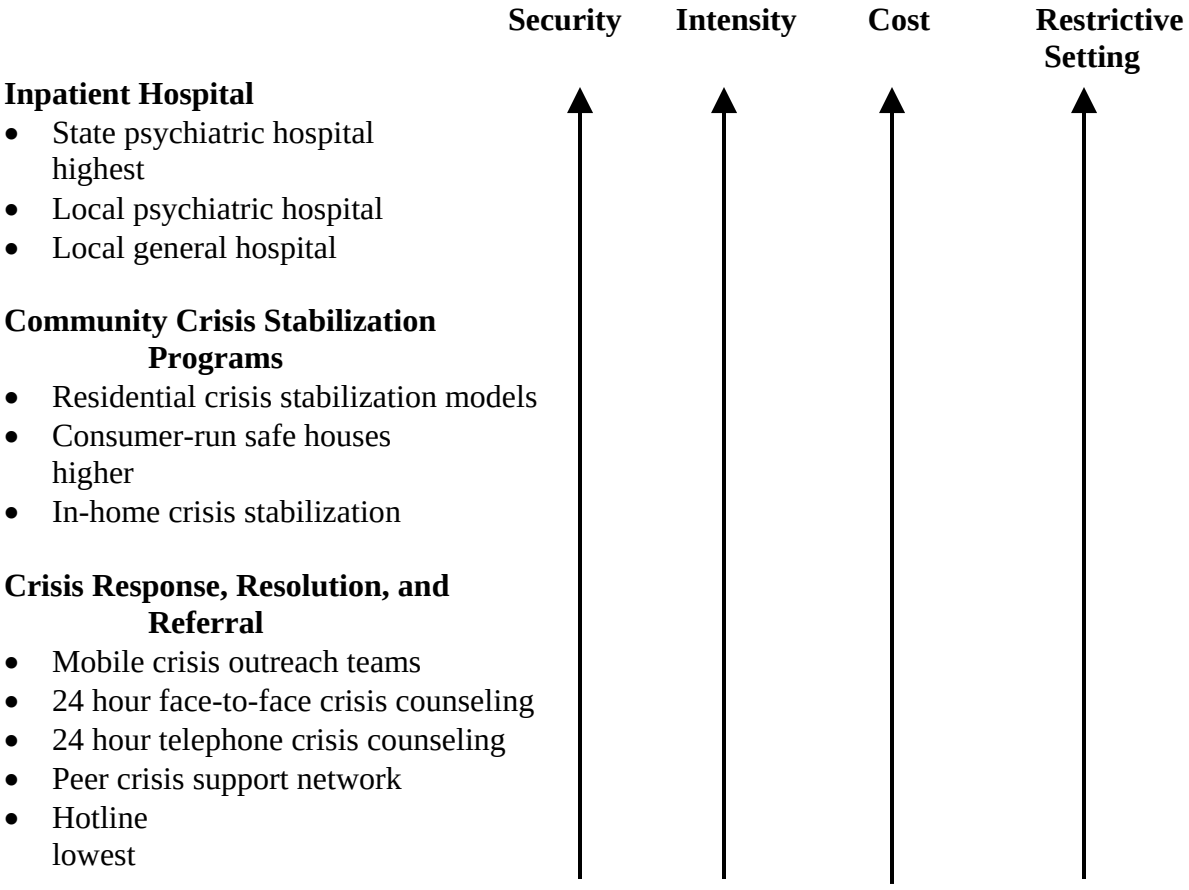
The findings and recommendations from this review of the CSB Emergency Services Programs (ESP) have been organized into two groupings – those that relate to **Access to Appropriate Services** and other findings that have an impact on **Quality of Care**.

Access to Appropriate Services – Findings and Recommendations

Each consumer served by an ESP presents a unique set of needs and issues. The diagnosis and symptoms of distress will vary not only by type but also by severity. There may be significant danger to self or others, or danger may not be a factor at all. The level of support available from family and/or community may be extensive or nonexistent. Depending upon these and other factors, the treatment plan will require differing degrees of service intensity provided in a range of settings that offer variable levels of security and restrictiveness. In order to provide the most effective crisis intervention – in the least restrictive setting - to each consumer, an emergency service program must have access to a comprehensive array of crisis intervention services.

A comprehensive continuum of crisis intervention services includes the services listed below. Each of the three groupings of services provides varying levels of security and treatment intensity. As the level of security and intensity of service increases, so does the cost of delivering the service and the restrictive nature of the setting.

Comprehensive Array of Crisis Intervention Services



The more comprehensive the array of services available in a community, the more effectively an ESP can tailor services to meet the specific needs of the individual at a given point in time. When the available service array is limited, the clinician is much more likely to select a more restrictive setting in order to assure safety. This results in treatment of the consumer in a program that is more restrictive and more costly than necessary.

The OIG administered a survey to all 40 CSBs in an effort to identify what crisis intervention services are available in each area of the state. The chart on the following page shows the results of this survey. Note that the chart is organized in the same fashion as the listing of comprehensive services above. Most secure and most intensive services are at the top – least secure and intensive services at the bottom.

Office of the Inspector General
Study of CSB Emergency Services

Crisis Intervention Services Continuum (Shaded items indicate community services not widely available)	# of CSBs Offering Service 24/7
Inpatient Hospital	
State hospital facility – State hospitals operated by DMHMRSAS	40
CSB hospital bed purchase - Contracted acute inpatient services in private hospital, often closer to home community; CSB involvement in admission, discharge, and treatment coordination more accessible.	35
Community Crisis Stabilization Programs	
Residential crisis stabilization (TDO) - Like the service below, but licensed to accept TDOs, with 24 hour nursing on site, M.D. daily and on-call for assessments and interventions. All of the current crisis stabilization programs are considering accepting TDOs.	2
Residential crisis stabilization service (voluntary) - 24 hour, CSB-operated or contracted, group home model, available in emergencies, sufficient staffing ratios to provide intensive supports to persons in crisis. Includes nursing on site and MD consultation/visits. (This model of crisis stabilization is currently used in three communities. The General Assembly funded seven additional programs 2005.)	9**
In-Home residential support service – CSB staff goes to the consumer's home and provide supports during crises, keep consumer safe and occupied. Level of support is matched to consumer need. Consumer-focused, not program-focused	6*
Consumer-run residential support service - "Safe house" program. CSB/consumer partnership agreement – many consumers prefer to be served by other consumers in a crisis.	2
Crisis Response, Resolution, and Referral	
Mobile outreach crisis team - Off site, face-to-face. ES clinicians go out to assess and serve persons in crisis wherever they may be, e.g., at consumer's home, on the streets, etc. Not just to hospitals, jails, etc.	9*
Psychiatric evaluation and medication administration. Face-to-face crisis medication evaluation and treatment. MD sees consumer, prescribes or administers meds, 24 hours a day.	1
Psychiatric crisis consultation – Telephone medication consultation with ES clinician or consumer; refill, change, call in prescription, etc. – routine, available by policy, not occasional exception.	12*
Face-to-face crisis counseling – immediate, 24 hours - With CSB ES clinician**,** without ECO or prescreening requirement. Crisis counseling to resolve or reduce crisis, therapeutic, talk as long as required to address consumer needs.	27
Face-to-face crisis counseling – guaranteed next day with CSB ES staff – Crisis intervention and treatment, may follow contract for safety (not an intake or referral for possible outpatient appointment)	27
Crisis consultation with CSB program (e.g., residential) – For current CSB consumer. ES staff contact the program staff who know the consumer and involve them in stabilizing the crisis, arranging for collaborative intervention, adapting program to address current needs, etc.	30
Telephone crisis counseling - extended - With CSB ES clinician. Crisis counseling on the phone, therapeutic intent, an effort to defuse crisis, provide crisis intervention.	39
Telephone crisis contact - brief - With CSB ES clinician. Initial screening, decision about whether to screen face-to-face, information and referral, assurance about medications, contract for CSB appointment	40
Hotline - a service where consumers can call and talk about their problems and be heard, at length if necessary. Staffed with volunteers, including consumers. Supervised and sponsored by CSB.	11

* Some have limited availability, are frequently unavailable, or restricted to current CSB consumers, etc.

** Only three programs are known to exist, but they extend service, when available, to other communities. Nine CSBs reported having access to such a service, but site visits revealed that lack of vacancies and transportation problems limited usefulness of some regional programs during a crisis.

Access Finding 1: The majority of Virginia's CSBs do not provide a comprehensive range of crisis intervention services for those with mental illness and substance use problems. Almost all CSBs offer the least restrictive Crisis Response, Resolution and Referral Services and most restrictive Inpatient Hospital Services, but very few offer the critical mid-range Community Crisis Stabilization Programs that effectively stabilize difficult crisis situations in the community. As a result, many consumers are denied effective treatment in the least restrictive setting and there is greater dependence on inpatient hospital care that is the most costly treatment alternative. As one family member put it, "You get either too much…or nothing at all."

- Only 13 (32.5%) of the CSBs offer or have limited access to one or more Community Crisis Stabilization Program alternatives. See chart above for number of CSBs having access to each type of service.
- Only 3 residential crisis stabilization programs exist in Virginia currently. As a result of funding provided by the General Assembly in the 2005 session, an additional 8 programs will become operational during FY06.
- Because crisis stabilization in the community has traditionally not been a part of the continuum of emergency services and is currently not widely available, Inpatient Hospital care is the only alternative for those who require more restrictive settings. 65% of staff interviewed and 51% of consumers interviewed said that the lack of local inpatient beds for acute care was the most significant need. When asked if the availability of Community Crisis Stabilization would help limit the demand for inpatient services, the answer was consistently yes.
- In the course of the 18 OIG site visits, a number of stories were told about consumers who were held in excess of the 4-hour legal limit of the ECO in local hospital emergency rooms for 24 to 36 hours. The explanation for these situations was that local psychiatric inpatient beds were unavailable or local beds were available but the private hospital refused the specific consumer and the regional state hospital also refused the admission.
- There is inconsistency across the state regarding safety net access to state hospitals when other alternatives for treatment in secure settings is not available

Access Recommendation 1a: It is recommended that DMHMRSAS, in cooperation with the Virginia Association of Community Services Boards (VACSB), conduct a short-term study to:

a. Identify and define the alternative types of Community Crisis Stabilization Services that are needed by CSBs to provide a comprehensive array of emergency services.
b. Determine which of these services if made available widely throughout the state would enable CSBs to improve their ability to serve consumers who are in crisis less restrictively.
c. Quantify the number and cost of each type of service that is needed.

DMHMRSAS Response: DMHMRSAS will refer this study request to the System Operations Team (SOT), which will convene a planning group of CSBs, consumers and other stakeholders to develop and implement this Community Crisis Stabilization Services (CCSS) study. To support this action, DMHMRSAS requests that the OIG make available the CSB-by-CSB data regarding the

availability of the continuum of CCSS statewide. The SOT study group will analyze gaps and needs on a local and regional basis to develop recommendations showing types, locations and costs of needed services, as well as implementation priorities and action steps. These findings and recommendations will guide budget allocations of new resources for CCSS. Target Date: June 30, 2006

Access Recommendation 1b: Based on the results of the study, it is recommended that:

- Individual CSBs and regional groupings of CSBs seek to identify ways in which current resources may be redirected to create crisis stabilization alternatives.
- DMHMRSAS request sufficient funding to enable the development of the needed Community Crisis Stabilization Services statewide.

DMHMRSAS Response: DMHMRSAS has collaborated extensively with CSBs, consumers, advocates and other stakeholders to develop an Integrated Strategic Plan that focuses on developing and sustaining a broad array of easily accessible, recovery-oriented, best practice services and supports, including Community Crisis Stabilization Services (CCSS). This work resulted in a preliminary 2007-8 biennium budget request for additional community crisis stabilization and crisis response services. This budget request also continues the progress made in FY 03, 04 and 05 in implementing a restructured, community based system of services that fosters and supports the Department's transformation vision. The SOT needs assessment study referenced above (Recommendation 1a) will incorporate additional VACSB and other stakeholder input to provide a solid foundation for budget planning in FY 2008 and subsequent biennia. (also see Response to Recommendation 2c, below)

Access Recommendation 1c: It is recommended that once projections can be made regarding the impact of the widespread availability of Community Crisis Stabilization, DMHMRSAS in collaboration with the VACSB, the Virginia Hospital and Healthcare Association and other stakeholders conduct a study to determine what level of local acute psychiatric Inpatient Hospital care is needed and develop strategies to address any unmet need(s).

DMHMRSAS Response: As CSBs, state hospitals and the Department have worked together to strengthen utilization management of acute inpatient resources, DMHMRSAS has learned that many factors influence the demand for inpatient care, and that some of these factors are not related to actual need for this level of care (this is confirmed by this OIG study). DMHMRSAS, in partnership with CSBs and other stakeholders, will re-examine the Commonwealth's needs for inpatient beds when the above study of CCSS needs is completed, and when other actions are taken to respond to the additional needs articulated in this report. Ultimately, however, the interdependence of many individual, community and regional factors will necessitate continuous reappraisal and realignment of inpatient beds and other community services, as well as the policy, infrastructure and funding that supports these needed services. DMHMRSAS will continue to collaborate

with all stakeholders to assure the availability of safety net services and effective stewardship of resources.

Access Recommendation 1d: It is recommended that DMHMRSAS develop consistent expectations for all state hospitals regarding

a. Admission of consumers when acute beds are not available in local community hospitals.
b. Admissions procedures during weekday, evening and weekend hours.

DMHMRSAS Response: This issue has already been identified by the System Leadership Council (SLC) and referred to the System Operations Team (SOT) for resolution. An SOT meeting is being scheduled to hear from HPR IV, Southwestern Virginia Training Center, and CO staff on current practices and issues related to admission and utilization management, disposition of consumers with mental retardation and co-occurring mental illness or behavioral challenges, and medical screening and assessment, respectively. Following this review, the SOT will develop a protocol to be followed statewide to address both of these expectations. Target Date: July 1, 2006

Access Finding 2: While the majority of CSBs offer the less intensive Crisis Response, Resolution and Referral Services, capacity limitations significantly restrict service effectiveness, especially in rural areas.

- The vast majority of CSB's do not have adequate psychiatric medical services available to consumers in crisis. Only one CSB offers face-to-face psychiatric services 24 hours per day. Only 11 CSBs offer direct emergency psychiatry services during weekdays and most of these restrict access to consumers who are currently on the active physician caseload. CSBs report that two factors contribute to the shortage – difficulty recruiting due to limited availability and insufficient resources. The problem exists in both rural and urban areas of the state.
- Only 9 of 40 CSBs routinely provide mobile ESP services to consumers wherever they may be – at home or even on the street. A larger number of CSBs provide limited mobile services to jails, hospitals, and other controlled settings.
- OIG telephone response time testing revealed that the length of time a consumer in crisis must wait to talk to a crisis clinician by phone varies significantly across the state. During the day, the wait exceeded 5 minutes at 10 (25%) of the CSBs. During the night the wait exceeded 15 minutes at 12 (30%) of the CSBs. See summary below. Details can be found in the Attachment Section of this report.

Length of Wait During Day	# of CSBs	Length of Wait During Night	# of CSBs
1 minute or less	14	1 minute or less	6
1 to 2 minutes	12	1 to 2 minutes	0
2 to 5 minutes	4	2 to 5 minutes	8

5 to 15 minutes	4	5 to 15 minutes	14
15 minutes or more	5	15 minutes or more	12
No response	1	No response	0

The most consistent explanation of delays was that the ESP clinician was already on the phone with a caller and the backup system required longer response or there was no backup clinician available.

- 68% of consumers reported that they are able to gain telephone access to an ESP clinician "quickly." 61% said that they were satisfied with the length of time it takes to gain face-to-face contact with a clinician. These comments did not differentiate between response time during office hours and after hours.
- 40% of community stakeholders reported experiencing or hearing about delays for ESP staff to appear for face-to-face evaluations. It was interesting to note, however, that over half who expressed this concern volunteered that they believed the problem was a lack of resources, insufficient staff, etc.
- Only 8 CSBs report having ESP staff on site in the office 24 hours a day. This is up from 5 in a survey conducted 5 years ago by the VACSB.
- 12 CSBs route night and weekend calls to ES staff on duty, trained volunteers, or a hospital – rather than through a non-clinical intermediary such as an answering service. Such an arrangement not only reduces time to reach a clinically competent responder, but also affords an opportunity for consumers in crisis to receive supportive counseling, which may be all that is needed.
- 28 CSBs use an answering service or 911 to receive crisis calls after office hours. Each time a call is received, the answering service calls the ESP on-duty clinician who returns the call to the answering service and then calls the consumer. Delays in response often occur when the on-duty clinician is already on the phone when a second call is received by the answering service.
- 33 of 40 CSBs have made arrangements to assure that callers are able to reach the ESP toll free from throughout the catchment area. For the remaining 7 CSBs, toll calls are limited to after hours. In these areas, consumers can call 911 toll free.
- CSBs have arrangements in place to serve consumers who speak different languages or who have special communication needs, however, delays often occur after hours when these special services are required.

Access Recommendation 2a: It is recommended that DMHMRSAS provide leadership to an initiative that will enable a sharing of psychiatric resources between state facilities and CSBs. This will result in maximizing the effectiveness of physicians who are already in the public provider system and will enhance the continuity and quality of care provided in facilities and in the community.

DMHMRSAS Response: DMHMRSAS' Medical Director will lead this effort and initiate discussion and planning around this issue at the next meeting of the medical directors of state facilities. In addition, the DMHMRSAS Medical Director will initiate communication with the Virginia Association of Community Psychiatrists to address this issue. DMHMRSAS, state facility and CSB medical leadership, and CSB ESP clinicians will collaborate to examine and implement strategies to make psychiatric consultation

accessible to CSB ES programs statewide. On-site consultation will be preferred, but the use of PolyCom and other tele-videoconferencing technology will be utilized to the fullest extent as well. In addition, this group will develop strategies to make training and education more accessible to CSB ES program staff and other key participants in the delivery of emergency services. This effort will be ongoing, and will include periodic assessments of the extent to which access to psychiatric resources has been increased statewide.
Target Date: Ongoing. Initial planning with facility and CSB medical leadership will be underway by December 30, 2005.

Access Recommendation 2b: It is recommended that each CSB routinely monitor the length of time required for consumers to gain telephone and face-to-face access to an ESP clinician during the day, night and weekend hours. If it is determined that response time is too long, to the extent possible within available resources, staffing and telecommunication equipment adjustments should be made to improve response time, especially with regard to accessing back up staff more quickly.

Access Recommendation 2c: It is recommended that DMHMRSAS request funding to enable CSBs to expand capacity and fill gaps in Crisis Response, Resolution, and Referral Services. As a result of this initiative, more psychiatric time will be available for direct service to consumers and consultation to ES staff; wait time will be decreased when multiple crises occur at the same time; greater mobility of emergency services will be enabled; ES staff will be able to provide more services by telephone and face-to-face.

DMHMRSAS Response: DMHMRSAS has collaborated extensively with CSBs, consumers, advocates and other stakeholders to develop a draft Integrated Strategic Plan that focuses on developing and sustaining a broad array of easily accessible, recovery-oriented, best practice services and supports, including Crisis Response, Resolution and Referral Services (CRRRS). This work has resulted in a preliminary 2007-8 biennium budget request for additional community crisis stabilization and crisis response services. The Integrated Strategic Plan and the 2007-8 budget request will be reviewed and refined to ensure that they specifically addresses the particular weaknesses of Virginia's ES system that were identified in this study. If funded, DMHMRSAS and CSBs will work together to increase availability of psychiatric time for direct service, reduce wait time by enhancing ESP coverage, increase mobility of ES services to provide more in vivo intervention, and provide more services face-to-face and by telephone. Periodic assessment of these CSB ESP capabilities will be conducted by DMHMRSAS and VACSB to monitor progress. The SOT needs assessment study referenced above (Recommendation 1a) will incorporate additional VACSB and other stakeholder input to provide a solid foundation for budget planning in FY 2008 and subsequent biennia. (See also Recommendation 1b, above)
Target Date: Ongoing

Access Finding 3: Most communities do not have access to appropriate crisis intervention for consumers with mental retardation. In addition, the role of state hospitals and training centers in

serving these persons is not clear. As a result: 1) consumers and staff are placed in dangerous situations and 2) consumers are referred to services that are not appropriate.

Access Recommendation 3a: It is recommended that DMHMRSAS conduct a study with the assistance of providers and recognized experts in the field of crisis and behavioral intervention for persons with mental retardation to:

a. Identify and define the continuum of crisis intervention services for persons with mental retardation.
b. Determine which of these services if made available widely throughout the state would enable CSBs to improve their ability to serve consumers with mental retardation who are in crisis.
c. Quantify the number and cost of each type of service that is needed.

Based on the results of the study, it is recommended that DMHMRSAS propose solutions and request sufficient funding to enable the development of the needed crisis intervention services for persons with mental retardation.

DMHMRSAS Response: DMHMRSAS and DMAS are currently working together to address certification and reimbursement issues related to the scarcity of behavioral specialist consultant services in Virginia. Resolution of these issues will expand the availability of these specialized services and benefit CSB ESPs. The System Operations Team is also reviewing issues related to the appropriate emergency services roles of CSBs, state facilities and training centers with respect to persons with mental retardation (see Recommendation 1d, above, and 3b, below). DMHMRSAS will refer the study recommended here to the SOT to be addressed through the process already underway with that group.
Target Date: October 1, 2006

Access Recommendation 3b: It is recommended that DMHMRSAS establish a statewide policy that clarifies the safety net role of the training centers in providing emergency services to consumers with mental retardation who demonstrate severe behavior management problems or may have a severe mental illness. This policy should state clearly what conditions are appropriate for emergency admission, which are not and when it is appropriate for an individual with either of these conditions to be admitted to a state mental health hospital.

DMHMRSAS Response: As described above, DMHMRSAS is working through the System Operations Team to address this issue. Currently, the SOT has identified a region (Far SW) where emergency treatment and disposition of persons with mental retardation and concurrent mental illness or severe behavioral problems is working well. However, each restructuring region statewide will be asked to develop and implement an appropriate emergency service response, including relevant protocols and services, to persons with mental retardation who demonstrate severe behavior management problems or who have a severe mental illness. Each regional response will include the specific responsibilities

of the DMHMRSAS psychiatric hospital and training center serving that region. The SOT will use this process to develop and implement statewide policy and guidance for state facilities and CSBs regarding evaluation, intervention and disposition of these consumers.
Target Date: Ongoing. Statewide guidance to facilities and CSBs will be completed by December 31, 2006 to coincide with the completion of the study referenced in recommendation 3a, above.

Access Finding 4: Non-emergency support and clinical services provided in the community do not have adequate capacity. As a result, ESPs deal with crisis situations that could have been prevented if the consumer had received more intensive or a different array of services.

- All CSBs that were visited by the OIG report that the limited capacity of their non-emergency psychiatric, case management, PACT, residential and outpatient services results in more crisis situations that could be prevented.
- The State Comprehensive Plan for MH/MR/SA Services, which is updated every two years as required by VA Code §37.2-315, documents significant unmet need for these services.

Access Recommendation 4: In order to prevent crises and therefore lessen demand on the emergency services system, it is recommended that DMHMRSAS and DMAS work cooperatively to seek avenues to steadily increase the capacity of the community services system to provide non-emergency support and clinical services.

DMHMRSAS Response: DMHMRSAS regularly meets with DMAS to discuss and resolve issues of policy and services. For example, DMHMRSAS and DMAS recognize the need for regional training and education about to providers regarding how to maximize funding for peer provided services under the current State Medicaid Plan. In addition, through the CMS Mental Health System Transformation Grant, DMHMRSAS, DMAS and CSB providers and consumers are exploring other potential avenues for enhancing reimbursement for evidence-based practices of supported employment, PACT and Illness Management and Recovery. These activities are consistent with Integrated Strategic Plan goals for provision and funding of evidence-based practices. Notwithstanding these and other activities, DMHMRSAS acknowledges that for several years, budget priorities for community services have been heavily focused on initiatives that reduced the demand for and use of state psychiatric hospital beds. Funding has mostly been targeted to PACT, purchase of community inpatient services, and the Discharge Assistance Program. At the same time, CSB non-emergency support and clinical services have eroded due to general fund reductions and the ever-increasing dependence on Medicaid revenues. Revamping and expanding Medicaid covered services that are aligned with recovery practices is envisioned in the Integrated Strategic Plan. The recovery vision delineated in the Integrated Strategic Plan must include a focus on wellness in order for that vision to be achieved. DMHMRSAS is fully committed to expanding non-emergency support and clinical services that are necessary to keep people from needing emergency services. DMHMRSAS will initiate discussions with DMAS to more aggressively utilize Medicaid

to leverage expansion of PACT services, outpatient and psychiatry services, residential services, etc.
Target Date: Ongoing

Access Finding 5: Current practices at public and private hospitals require medical evaluations to rule out non-psychiatric explanations for behavioral symptoms and to assess the presence of medical conditions that may exceed the treatment capabilities of the psychiatric facilities. Many ESP staff and stakeholders believe that these practices have become excessive, are inconsistent among hospitals, and may exceed the requirements of the current code for "emergency treatment." The delays, costs, legality, and inconsistency among hospitals of these practices are a major source of concern among stakeholders, hospital medical emergency rooms, and consumers.

- Hospital selectiveness and requirements for medical clearance were identified as the major contributors to the hospital bed access problem.
- Hospitals providing medical clearance services report un-reimbursed costs (often as much as $2500 per case).
- Long delays in obtaining medical clearance and in finding a willing facility to accept a person often exceed the four-hour limit established by Va. Code for Emergency Custody Orders (ECO). In these cases law enforcement officers may continue to hold a person without legal authority or some magistrates will issue a second ECO. While not consistent with the Va. Code, both practices do assure the safety of a consumer whom the CSB has determined is in need of detention. In the survey month of March 2005, CSBs reported that 37 children and adults were released against clinical judgment because ECOs lapsed.
- Differences of opinion and practice exist among CSBs, hospitals, magistrates, and local law enforcement personnel regarding Va. Code requirements for medical clearance and transportation. For example, some magistrates will not issue Temporary Detention Orders (TDO) to include transportation for medical clearance; some sheriffs will not transport consumers for medical clearance unless emergency care is needed.

  Access Recommendation 5a: It is recommended that the Code of Virginia be amended to clarify that medical screening is an authorized activity under TDO procedures.

  DMHMRSAS Response: This activity is currently underway with stakeholders through the Interagency Civil Admissions Advisory Council (ICAAC). DMHMRSAS is also working with DMAS to identify areas of flexibility in the current regulatory process that would allow payment for medical screening without Code change.
  Target Date: July 1, 2006

  Access Recommendation 5b: It is recommended that DMHMRSAS develop and implement clear and consistent standards regarding medical clearance for all state hospitals and work with the Virginia Hospital and Health Care Association, and other appropriate bodies, to achieve a similar outcome for private hospitals.

DMHMRSAS Response: DMHMRSAS, VACSB and VHHA collaborated several years ago to refine medical screening and assessment expectations and procedures for state facilities, CSBs and private hospitals. DMHMRSAS will initiate a review of these procedures with state hospital medical directors and other stakeholders, and update these protocols to reflect current consensus best practices. DMHMRSAS will also work with VACSB and VHHA partners to develop and provide necessary training to regions and stakeholder groups to ensure that stakeholders are informed and that there is effective implementation and effective oversight of medical screening and assessment practices. DMHMRSAS will integrate these medical screening and assessment expectations into a Departmental instruction and disseminate this with implementation guidance to each facility director and facility medical director. DMHMRSAS will also pursue policy change with DMAS to allow medical screening and assessment to be reimbursed through the Involuntary Mental Commitment Fund, and DMHMRSAS will propose legislation through the Interagency Civil Admissions Advisory Council to allow payment from the IMC Fund for medical screening and evaluation at any phase of the emergency custody and temporary detention process.
Target Date: Ongoing. Medical Screening protocols and procedures for state facilities will be updated, disseminated and implemented by July 1, 2006.

Quality of Care – Findings and Recommendations

In addition to timely **access** to an appropriate range of crisis intervention and stabilization services, the OIG study focused on the **Quality of Care** provided to consumers by CSB ESPs. These findings and recommendations are as follows:

Quality of Care Finding 1: Virginia's CSB system of emergency services is staffed with well qualified, experienced, highly motivated, and well-supervised staff. Staff knowledge of the adult mental health population is stronger than it is for other consumer groups. Ongoing training for ESP staff is limited. The system of certifying CSB emergency prescreeners needs to be updated and standardized.

- Review of personnel records and staff interviews showed that the overwhelming majority of ESP clinicians are clinically well qualified and receive excellent supervision and support from experienced clinical supervisors.
- 83 per cent of consumers and 91 per cent of stakeholders interviewed said that ESP staff are qualified. Often these comments were expressed with enthusiasm or warmth.
- The majority of ESP staff are very experienced in the provision of crisis intervention services. The average tenure of direct service ESP staff is 4.6 years in providing emergency services. All but a few staff have masters degrees, and 51 per cent are licensed. ESP supervisors have an average of 13.8 years of emergency services experience.
- All but a few pre-screeners have been certified under procedures developed by DMHMRSAS in response to General Assembly action. All CSBs understand and

maintain the pre-screener certification process, although some do so more completely and thoroughly than others.

- CSBs use different processes and forms to document pre-screener certification. Guidelines for this process have not been reviewed and updated by DMHMRSAS since originally introduced in 1998-1999.
- ESP staff have excellent knowledge of crisis issues, crisis counseling, assessing risk of suicide and mental status exams for adults with mental health problems, however:
    - They are less knowledgeable of medications, medical issues, the civil commitment code and available services in the region and state.
    - They have limited knowledge regarding the service needs for those with substance use problems, children, adolescents, and the elderly.
    - Few reported knowledge or interest in mental retardation issues.
- Few staff receive ongoing formal training on topics related to emergency services (e.g., code requirements, how to serve various populations in crisis, etc.)
- Very few staff (or supervisors) are facile and knowledgeable in discussing crisis service options beyond the services offered by the CSB. Few staff readily identified crisis service continuum options such as those described in the OIG survey chart on page 12 of this report.

Quality of Care Recommendation 1a: It is recommended that DMHMRSAS, with the assistance of CSBs, update and clarify requirements for certification of CSB pre-screeners. New training materials should be developed. The DMHMRSAS Office of Licensure should inspect compliance.

DMHMRSAS Response: Workforce and training issues are an important part of the Integrated Strategic Plan. DMHMRSAS will update the existing certification requirements and materials in collaboration with the VACSB (including the VACSB Emergency Services Managers), consumers and other stakeholders. DMHMRSAS will ensure that the updated certification process strongly and explicitly embodies the vision of a system of services that promotes self-determination, empowerment, recovery, health and resilience. This process will also be utilized to develop an ongoing EOS "Training Plan" (see Recommendation 1b, below) and to update the Uniform Pre-Admission Screening Form (See Recommendation 4, below).
Target Date: December 31, 2006

Quality of Care Recommendation 1b: It is recommended that DMHMRSAS and CSBs collaborate in developing and sponsoring regular training regarding a wide range of topics related to crisis intervention services including intervention with special populations.

DMHMRSAS Response: DMHMRSAS currently supports relevant training in civil mental health law in collaboration with the Institute of Law, Psychiatry and Public Policy and the office of the Attorney General. The Department also supports the bi-annual VACSB Emergency Services Conference and sponsors other events on an ad hoc basis (such as the HPR II Recovery Conference in 2004) as resources allow. In keeping with the Integrated Strategic Plan, DMHMRSAS has already made a preliminary budget request

for funding to establish two "Centers of Excellence" which will enable DMHMRSAS to partner with organizations with an educational mission (such as universities) to plan, provide, coordinate and support ongoing training in recovery-oriented best practices for Virginia providers. Regarding EOS, DMHMRSAS will convene the VACSB (including Emergency Service Managers), consumers and other stakeholders to review the specific training needs of EOS workers, especially pertaining to provision of effective ES services for children and youth, individuals with substance use disorders and mental retardation, and elderly service recipients. This group will develop an ongoing EOS "Training Plan" including specific strategies to meet training needs and accomplish training goals. Target Date: December 31, 2006

Quality of Care Finding 2: CSB ESPs are sensitive to the importance of providing for the safety and privacy of consumers who are served in crisis. Whenever possible they arrange to provide services in settings that are not stigmatizing. Few provide mobile emergency services in the locations most preferred by consumers – their own homes or in the community.

- The OIG found clinical decisions to release or detain consumers to be appropriately safe, with no observed instances of release of persons who should have been detained for safety.
- 81 per cent of interviewed consumers said they felt safe and protected when they were served by the ESP program; 91 per cent of staff indicate that their services are safe for consumers.
- CSB staff reported that they feel safe themselves when seeing consumers in crisis and were able to cite appropriate safeguards that assured safety.
- There is wide variability among CSBs in the degree to which mobile crisis intervention services are provided. While resource limitations were often cited as the reason for not providing mobile services, the OIG observed that CSBs with comparable resources had varying practices regarding mobility.
    - Only 9 of the 40 CSBs reported that they provide fully mobile outreach - seeing consumers in their homes or wherever they may be (usually with police accompaniment).
    - Many more reported that they do go out to see consumers who are in crisis at supervised, safe locations such as schools, CSB program sites, assisted living facilities, hospitals, and jails.
- Newer, CSB-designed and owned facilities incorporate excellent separation, safety, privacy, and efficiency for ESP services.
- The hospital emergency departments used by CSBs for crisis intervention are mostly modern, efficient facilities with accessible services to determine medical clearance. These setting, however, most often do not afford privacy for persons in psychiatric crises.
- The hospital emergency room was the most common after hours site for serving consumers in crisis. A few CSBs reported that when law enforcement agencies are involved with the crisis they insist that the consumer be seen at the jail or sheriff's office rather than at the CSB's office or local hospital. This is particularly true in rural areas.
- Consumers state strongly that they are very uncomfortable and feel stigmatized when they are taken to a law enforcement facility to receive mental health services.

- Use of handcuffs and shackles by police and sheriffs during civil commitment transportation varies among localities, but are universally resented by consumers and families.
- Police chiefs and sheriffs, especially in rural counties and towns, report that personnel are delayed for hours on civil commitment processes causing high personnel costs and diminished public safety coverage

Quality of Care Recommendation 2a: It is recommended that CSBs work actively to increase the use of mobile emergency services, seeing consumers in their home and community. It is also recommended that CSBs and local law enforcement agencies work together to increase their collaboration for the purpose of assuring safety for mobile crisis intervention staff.

Quality of Care Recommendation 2b: It is recommended that CSBs and local law enforcement agencies make every effort to assure that crisis intervention services are provided in settings that are comfortable for consumers and decrease stigmatization.

Quality of Care Recommendation 2c: It is recommended that statewide sheriff, police and CSB associations work collaboratively to develop guidelines for safe and non-stigmatizing transportation of consumers in the civil commitment processes.

Quality of Care Finding 3: All CSBs that were visited by the OIG have mission statements, and staff are generally familiar with the direction set for the organization. A number of CSBs do not have clearly stated operational values or guiding principles. While many of the CSB ESPs consider treatment in the least restrictive setting an important focus of their efforts, the availability of a limited array of crisis intervention services often prevents the realization of this intent. The majority of staff are not familiar with the recovery model which is a major component of the system vision statement recently adopted by DMHMRSAS.

.

- 32 per cent of staff described a mission for their ESP that was limited to civil commitment prescreening.
- 67 per cent described a broader mission of crisis intervention or clinical care for persons in crisis.
- Only 19 per cent of those interviewed used recovery model language (consumer choice, empowerment, self-determination).
- Only 21 per cent of staff reported familiarity with the recovery model; only a few supervisors reported training on it.

Quality of Care Recommendation 3a: It is recommended that each CSB review its mission statement and make any needed changes to assure consistency with the system-wide vision statement adopted recently by DMHMRSAS. Once this is done, each CSB should review its strategic objectives and initiatives to assure that these are consistent with the system vision statement and revised CSB mission statement.

Quality of Care Recommendation 3b: It is recommended that each CSB develop a clearly stated set of values or principles that are consistent with the system vision

statement. The purpose of these values or principles will be to guide how services are delivered to residents and how the CSB will relate to the broader system of care. Once these statements are established, each CSB should take the necessary steps to assure that the actions of staff at all levels and the culture of the CSB reflect the value or principle statements.

Quality of Care Recommendation 3c: It is recommended that DMHMRSAS, in conjunction with a representative group of CSB staff, state mental health facility staff and consumers, develop a training curriculum that is competency based regarding the principles of recovery. Once this curriculum is completed, training should be made available to CSBs, state facilities and licensed private providers.

DMHMRSAS Response: This recommendation is in the Integrated Strategic Plan. DMHMRSAS strongly supports this recommendation and has submitted a request for funding for state funds to partner with two universities to develop and provide such education (see Recommendation 1b, above).
Target Date: December 31, 2006

Quality of Care Finding 4: CSB emergency services decisions regarding whether to detain or release consumers in crisis are consistently competent. These decisions are well documented and the documentation supported the clinical decision. These practices were consistent across the state.

- State facilities and private hospitals, which receive consumers prescreened by CSBs, indicated that they generally concur with the clinical findings and recommendations of the CSBs.
- Records at CSBs revealed that assessments were clinically competent. Case records supported the clinician's judgment to recommend release or detention of consumers.
- Clinical decisions about the need for detention based on danger to self or others were generally comparable across all CSBs that were inspected. It was found that one ESP has a greater propensity to detain than others across the state and this finding was communicated to the leadership of that CSB.
- Based on a 20-point clinical record measurement tool, all but a handful of 140 records were judged to provide good documentation.
- Review of records with ESP staff often highlighted the need to revise and update the Uniform Pre-Admission Screening Form. A number of ESP staff stated that they could be more efficient if an electronic version of the form could be made available.
- Occasional incomplete records were found. In most cases, this was a result of failure to fully complete the Uniform Pre-Admission Screening Form in situations where the consumer was seen only briefly and released.

Quality of Care Recommendation 4: It is recommended that DMHMRSAS, with the assistance of CSBs and private hospitals, revise and update the Uniform Pre-Admission Screening Form and make it available in electronic form.

DMHMRSAS Response: DMHMRSAS recognizes that this form needs improvement and has already agreed to initiate a review and update of the Uniform Pre-Admission Screening Form with CSBs, private hospitals and the Office of the Attorney General. This action originated in response to a request made by HPR I CSBs. An electronic version of the form will also be made available. The work group referenced above (see Recommendations 1a and 1b) will accomplish this task.
Target Date: September 1, 2006

Quality of Care Finding 5: Few CSBs report formal systems to monitor and improve effectiveness and quality of their emergency services. Nevertheless, feedback to the OIG by consumers and stakeholders revealed general satisfaction with the services.

- A minority of consumers (35 per cent) report that ESP staff asked them for feedback or their opinion on how well the services met their needs.
- 57 per cent of all stakeholders interviewed said the CSB never has asked them whether the service met their needs or how it could be improved. 51 per cent, however, said they felt they could make their views known to the CSB.
- Although most CSBs set a standard for their responsiveness to crisis calls, few actively tested or monitored responses.

Quality of Care Recommendation 5: It is recommended that each CSB develop a process for routinely seeking evaluative comments from consumers, families and community providers regarding the quality of services provided by the CSB programs, the effectiveness of the CSBs relationship with the broader provider service system, and general satisfaction with services.

Quality of Care Finding 6: ESP services are well coordinated with other CSB services for consumers, with generally good communication across programs.

- Communication and coordination between ESPs and other CSB operated mental health and substance services were generally found to be good. Coordination between ESPs and mental retardation services was a significant problem in some settings.
- No CSB visited has a system of developing and accessing crisis plans or advance directives.
- Only the eight CSBs that have 24 hour on-site staffing have the ability to access full clinical records to learn about current treatment of CSB consumers they see after hours.
- About a third of the CSBs have the ability after hours for ESP staff to determine whether or not a consumer is currently being served by the CSB and some basics about their condition. Only one CSB reported that it has electronic record accessibility off site after hours.

Quality of Care Recommendation 6a: It is recommended that CSBs work with consumers to develop advance directives or crisis plans in which consumers identify preferences, resources and requests that should be honored if the consumer experiences a crisis. These plans should be accessible to ESPs at all times.

Quality of Care Recommendation 6b: It is recommended that CSBs, with the assistance of DMHMRSAS, move toward electronic record systems that are accessible by ESP staff around the clock, as soon as possible.

DMHMRSAS Response: The DMHMRSAS and the VACSB have submitted a proposal to the Governor's Council on Technology in Health Care for a pilot project in Southwest Virginia that will electronically link SWVMHI and at least three areas CSBs for the purpose of sharing behavioral health information. Budget proposals have been submitted for the project and a planning structure is being established. The proposed project will be implemented in partnership with Frontier Behavioral Health, Inc., a public behavioral healthcare provider in Southwest Virginia and Tennessee. The partnership with Tennessee, which has already has implemented a model for information sharing among diverse healthcare providers, will give us the benefit of its experiences in structuring, funding, and managing a regional health information network. This effort is endorsed in the Integrated Strategic Plan. This project and planning process will be utilized to study how electronic records could be implemented to enhance delivery of ES service, and specific strategies to implement effective approaches will be developed.
Target Date: December 31, 2006

Quality of Care Finding 7: Each ESP has a well-developed policy and procedure manual that includes resources to assist staff in serving consumers. ESP staff have knowledge and understanding of the policies and procedures that apply to the ESP. Clinical records reflect compliance with applicable policies and procedures.

No recommendations

Section IV

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs
General Observations

Services for persons with substance use disorders

While most of the language used in the report deals with adult mental health issues, the review dealt extensively with substance abuse services needs and needs of persons with dual diagnoses of substance abuse and mental illness. Interviews with CSB staff and stakeholders emphasized the shortage of both crisis stabilization and basic support services for persons with substance abuse and addiction problems. Only 26 of the 40 CSBs reported having access to a social detoxification program. Of those, many complained about bed shortages due to programs being full and transportation problems to distant sites. As neither these consumers nor these sites are eligible for TDO status, transportation is not provided by law enforcement agencies. An even less available service is medical detoxification. Only 18 CSBs report having access to this type of service. Lack of basic clinical support services for persons with substance use disorders was at least as great – or greater, due to the non-availability of Medicaid support for such services – as the situation for mental health services.

Children's services

Interviews with all staff and stakeholders focused equally on children and adults. The findings and recommendations for children's services are encompassed in the general findings and recommendations. Special note was made by many staff and stakeholders of the additional travel and inconvenience imposed by code requirements that the hearings for children take place in their home communities, often requiring multiple and duplicative trips by sheriff and police offices to transport children who have been placed in hospitals.

Budget analysis

An analysis of expenditures for emergency services by CSBs is found in the appendix, page 43.

Section V

Office of the Inspector General
Review of Community Services Board - Emergency Services Programs

Appendix

A. Emergency Services Quality Statements (Detailed)

B. Telephone Response Tests of CSB Emergency Services

C. Inspection Schedule

D. Emergency Services Best Practices

E. CSB Budget Information

F. Survey Questionnaires and Checklists (available in OIG web site version or by request – not included in printed versions)

1. 40 CSB ESP Survey
2. CSB Staff Interview
3. Stakeholder Interview
4. Consumer Interview
5. Family Interview
6. CSB Site Observation Checklist
7. Clinical Record Review
8. DMHMRSAS Facility Review of CSB ESPs
9. Telephone Response Test Survey

Section V.A

Office of the Inspector General
Emergency Services Quality Statements and Elements (Detailed)

1. **The work of the emergency services program (ESP) is guided by a clearly stated mission statement and principles or values. These statements are understood by staff and guide their work**.
   - The agency and/or the ESP has a mission statement.
   - The agency and/or the ESP has a statement of values and principles.
   - Staff are familiar with the mission statements and principles.

2. **The emergency services program has clearly developed policies and procedures that provide guidelines for practice. ESP practices comply with policies.**
   - A written policy and procedure statement exists for the ESP.
   - ESP staff demonstrate awareness of the policy and procedure manual and can identify its location and intended use.

3. **The emergency services program assures that all staff providing crisis intervention services are qualified to provide these services and there is competency training and a system for assessing competency in place to assure that all staff have the skills to meet the needs of consumers.**
   - All staff who provide prescreening services are certified by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services.
   - Staff have clinical knowledge, skills, and abilities to provide crisis intervention services as evidenced by clinical training and demonstrated competence.
   - ESP staff have knowledge of mental health, mental retardation, and substance abuse clinical issues, medications for mental illnesses, medical issues, children, adult, and aging issues, the civil commitment code, and available services in the region and state.
   - The CSB assures current clinical preparation of ESP staff through a comprehensive program of training and competence testing.
   - Clinical and administrative supervision and backup for ESP clinicians is provided by policy and practice.

4. **Emergency Services, including both crisis intervention and prescreening services, are available at all times and easily accessible in a timely fashion.**
   - The ESP program is accessible 24 hours a day, 365 days a year.
   - The ESP program access telephone numbers are widely publicized and well known in the community.
   - Callers can reach the ESP from any location in the CSB catchment area without telephone toll charges.
   - Callers reach a live answering person when calling the listed emergency services number at any hour of the day with a minimum of transactions.

- Callers reach telephone-answering staff that is trained in basic issues of crisis intervention and mental illness issues.
- Callers who speak different languages or who have special communication needs are reasonably accommodated at the first call and thereafter.
- The CSB has an expectation for crisis telephone and face-to-face response and an active system for measuring compliance with the expectation.
- There is evidence of a continuous quality improvement system with regard to accessibility and responsiveness.
- Back-up systems exist for timely response to multiple crises at all hours.
- Every jurisdiction served by the CSB has a reasonable opportunity to receive timely services, at all hours.
- Consumers, families, and other stakeholders are queried regularly about their perceptions of the adequacy of ESP access and responsiveness, and their assessments are satisfactory.

5. **The Community Services Board offers an array of intervention services that address the emergency needs of the community and its citizens.**
   - Services are available to respond to the crisis needs of consumers, their families, and referring stakeholders, rather than only provide civil commitment processing.
   - Policies, procedures, and practices reflect a priority of ameliorating crises and reduction of distress with the least restrictive alternatives.
   - Civil commitment processing (requesting Emergency Custody Orders, assessments for Temporary Detention Orders, etc.) is not the primary response of the ESP to crises.
   - Consumers receive services that are responsive to their needs and preferences.

6. **Crisis interventions are guided by sound clinical judgment and seek to meet consumers' needs with the least restrictive option for care, with involvement and choice for the consumer.**
   - Clinical assessments of crisis intervention needs and risks are clinically competent.
   - Crisis interventions are guided by sound clinical judgment and seek to meet consumers' needs with the least restrictive option for care, with involvement, identification of strengths and resources, and choice for the consumer.
   - There is evidence in the clinical record that an assessment of the consumer's competence to participate in decisions has been assessed.

7. **Services are provided in a manner that supports consumers in feeling safe and fosters treatment with dignity and respect. The location of emergency services provides for confidentiality, privacy, consumer comfort, and security.**
   - The ESP provides its services in locations that consumers consider comfortable, safe, welcoming, and confidential.
   - ESP operations, including the presence of law enforcement officers and vehicles are reasonably separate from other CSB consumer service or public service operations.
   - The ESP avoids the use of locations that add negative stigma to the crisis intervention process, such as jails, police stations, or other criminal justice system locations.

- The ESP provides its services predominately in environments that it can design and control in accordance with its consumer-focused values.
- If ESP services are provided in a hospital emergency room, appropriate arrangements exist to allow the consumer to receive treatment and be served in an environment that is in accordance with consumer-focused values.
- Consumers being served by an ESP are rarely left alone and are helped to understand the legal and clinical processes they are experiencing.

8. There are systems in place to monitor and continuously improve the effectiveness of the emergency services provided, including consumer and stakeholder satisfaction.

- The ESP routinely surveys consumer satisfaction with services and reflects their input in its service operations.
- The ESP maintains regular communication with the network of stakeholders it works with (judges, magistrates, law enforcement, referring agencies, hospitals, etc.), requests their feedback, and keeps them informed of program developments.
- Clinical supervisors regularly review clinical records and provide feedback and direction to ESP staff.

9. Emergency services complement, support, and are well coordinated with the other services consumers' receive from the CSB.

- CSB program services, where the staff and consumers are known to each other, are capable of providing crisis intervention and do so as the first resort, rather than referring all crises to the ESP.
- CSB program services alert ESP staff about developing crises situations and jointly plan supportive, least restrictive contingencies should the consumer require emergency services.
- The CSB has an active program of helping consumers and families prepare advance directives or route plans and such plans are on file with the ESP.
- The ESP routinely inquires with the consumer in crisis about advance directives and requests permission to inform family members about the developing crisis situation and the consumer's whereabouts.
- The consumer's clinical record, to include medication records, is available to the ESP staff on a 24-hour basis.
- The CSB program staff, to include the consumer's psychiatrist is available on call to the ESP to assist with a consumer's crisis and is considered the first option for least restrictive care.
- The ESP informs the CSB program staff about crises developments within 12 hours (the next morning, for example) of a crisis incident.

Section V.B

Office of the Inspector General
Response Tests of Community Services Board
Emergency Services Programs

Methodology

OIG staff conducted unannounced telephone response tests of each of Virginia's 40 CSBs. OIG staff, acting as surrogate consumers, called each CSB twice, once during regular office hours, and once at night or on the weekend. Callers used the emergency services phone number provided by the CSB, when available, or called the CSB main office. Calls were timed with stopwatches from the time the number was dialed to the time the caller was connected with an emergency services clinician. This technique included the time taken by the number of rings before someone answered, transfers to other numbers, time on hold, and wait time for clinicians to pick up or call back. This approach measured the totality of the consumer's experience in calling and tested the efficiency and responsiveness of administrative support services as well as that of clinicians.

Callers used a protocol that was designed to portray a consumer in need with urgency, anxiety, and desire for anonymity, but without falsely communicating a life-endangering situation that might seriously divert ESP or law enforcement resources or endanger care of consumers concurrently being seen in crisis. Callers asked to speak to an emergency services clinician. When administrative staff or answering services requested more information and details, OIG staff simply said, "I just want to speak to a crisis counselor as soon as possible." Every effort was made to place calls from telephones within the area code of the CSBs being surveyed. If pressed beyond a few requests by answering service, 911 dispatchers, or other telephone responders to provide identifying information, OIG staff then revealed their true identity and purpose of the call. In these situations OIG staff requested that this information be kept confidential when paging or calling the ESP on-call staff. Immediately upon being contacted by an emergency services clinician, OIG staff revealed their identity, the purpose of the call, and provided feedback for the worker.

Results

The entries below include elapsed time between dialing number and contact with ESP clinician. One call was made during office hours and one call was made after hours.

Community Services Board	Office Hours Response Time	After Hours Response Time
Alexandria	0:29:06	0:00:31
Allegheny Highlands	0:01:42	0:21:04
Arlington	0:00:24	0:00:06
Blue Ridge	0:00:08	0:03:34

Community Services Board	Office Hours Response Time	After Hours Response Time
Central Virginia	0:05:52	0:21:07
Chesapeake	0:16:08	0:53:21
Chesterfield	0:00:11	0:03:47
Colonial	0:01:39	0:04:23
Crossroads	0:01:12	0:11:32
Cumberland Mountain	0:00:25	0:06:32
Danville-Pittsylvania	0:08:42	0:38:53
Dickenson County	0:01:20	0:05:53
District 19	0:00:19	0:20:38
Eastern Shore	0:04:50	0:08:14
Fairfax-Falls Church	0:00:16	0:00:09
Goochland-Powhatan	0:01:17	0:06:28
Hampton-Newport News	0:02:58	0:12:34
Hanover	0:00:06	0:03:21
Harrisonburg-Rockingham	0:01:44	0:11:41
Henrico	0:00:08	0:00:12
Highlands	0:01:23	0:04:16
Loudoun County	0:01:51	0:03:41
Middle Peninsula-N. Neck	0:00:54	0:07:18
Mt. Rogers	0:01:13	0:05:48
New River Valley	0:01:00	0:42:00
Norfolk	0:00:13	0:25:09
Northwestern	0:01:20	0:21:00
PD1	0:05:05	0:05:42
Piedmont	0:00:18	`0:00:19
Portsmouth	0:09:52	0:10:44
Prince William County	0:00:58	0:20:01
Rappahannock-Rapidan	0:34:00	0:18:00
Rappahannock Area	no response	0:17:00
RBHA	0:00:08	0:00:07
Region Ten	0:00:45	0:03:11
Rockbridge	0:02:30	0:37:00
Southside	0:01:32	0:09:15
Valley	0:26:00	0:03:00
Virginia Beach	0:29:18	0:22:27
Western Tidewater	0:03:29	0:05:04
Mean (average)	0:05:08	0:12:125
Median	0:01:20	0:06:30

Discussion

Daytime - No clear standards exist for response times, but the OIG used the following considerations. Day time office-hour calls optimally would involve one transfer and could take as little as a few seconds to under a minute – excellent, virtually immediate service. A call that is answered in the "managed care standard" of three rings, followed by a brief discussion between the consumer and the receptionist, then another three-ring transfer to a clinician could take from 90 seconds to two minutes – good service. Twenty-six CSBs had office hour response times that were under two minutes. The OIG staff considered a wait of five minutes or more as excessive, especially for a person in crisis during day time hours. Ten CSBs recorded office-hour response times of over five minutes. In most cases of slow response times, the ES workers explained that they were with a consumer or on the phone with another crisis and had no back up available. Delays of significant length (over 15 minutes) occurred in 6 cases. These were clear system breakdowns. In one case where no response was received, a series of calls were directed to a voice mail.

Evenings and Weekends - Response times during the evenings and weekends are expected to be slower, as calls are usually received by an answering service or 911 office, that then pages the on-call worker, who then calls back to get the consumer's phone number and circumstances, and then calls the consumer. CSB survey data showed that 15 minutes is the most widely accepted standard for these calls. Six CSBs recorded after-hour responses lower than the best daytime standard of less than two minutes. Overall, including these responses, 32 CSBs responded more quickly than the 15 minute "standard", an excellent performance. Twelve responses were poor – over 15 minutes – with four excessively long delays that constitute system breakdowns. As with daytime calls, most workers explained that they were already on a call. Four mentioned equipment failures or unfamiliarity with equipment.

In general, back-up systems were not activated smoothly and quickly in cases where the CSB "first responder" could not be reached. When the on-call staff member was too busy to respond to a second or third emergency, he or she tended to wait until time was available to answer the page(s), instead of finding some way to alert the answering service to seek back up. However, it is understood that interrupting a crisis intervention to make even a brief call to the answering service or back up could be inappropriate. In a few cases the answering service made a second page and then took the initiative to call the back up when there was no response.

Section V.C

OIG Emergency Services Inspection Schedule - 2005

Date	Community Services Board
May 19- 20	New River Valley CSB – Blacksburg
May 24-25	Valley CSB - Staunton
May 27	Allegheny Highlands CSB – Clifton Forge (return June 3)
June 1-2	Central Virginia CSB – Lynchburg
June 7- 9	Eastern Shore CSB – Nassawadox Norfolk CSB
June 14- 15	Richmond BHA – Richmond
June 22 – 23	Rappahannock-Rapidan CSB – Culpeper Rappahannock Area CSB – Fredericksburg
June 29 – 30	Crossroads CSB – Farmville
July 6-7	Virginia Beach CSB Portsmouth CSB
July 11 – 13	Alexandria CSB Fairfax-Falls Church CSB* Loudoun CSB – Leesburg
July 21 – 22	District 19 - Petersburg Danville-Pittsylvania CSB
August 15-16	Mt. Rogers CSB – Wytheville

* Crisis stabilization center and Woodlawn outpatient center only, not a comprehensive study of the entire ESP.

Section V.D

Best Practices in CSB Emergency Services Programs

During visits to 18 CSBs OIG staff encountered many excellent programs and innovative program ideas. Here are some of the "best practices" and good ideas that were found. CSB staff and others may wish to contact their colleagues at these CSBs to learn more about these services. Apologies are offered to any CSB where OIG staff might have missed a good idea that should be shared. The 22 CSBs that were not visited by the OIG are invited to share their "best practices" with the OIG and other CSBs.

Alexandria CSB
William E. Taylor, LCSW, Emergency Services Team Leader
703-838-6400
William.Taylor@alexandriava.gov

- Residential mental health services feature improved clinical supervision for mental health support service staff, improving their ability to recognize and deal with psychiatric crises.
- The CSB provides on site ESP staff until 9:00 P.M. During the hours that the main CSB offices are closed (after hours, weekends, etc), ESP staff provide outreach services in the community (at the Detox Center, Shelters, CSB residential sites, etc.). Staff make "rounds" at various sites throughout the community to check-in with staff and consumers - offering support and intervening with/evaluating consumers when indicated.

Allegheny Highlands CSB
Pat Bradley, Clinical Services Director
540-965-2100
@AOL.com

- Residential staff have developed a limited crisis stabilization capacity in which persons in crisis may receive up to 8 hours per day of crisis stabilization services in their own home or group home for up to 15 days. Existing staff is augmented with other staff and services are billed to Medicaid. Services may also take place at the CSB or in the community.

Central Virginia CSB
Terrell Cosby, Program Manager
434-455-3477
terrell.cosby@cvcsb.org

- The CSB has separate and specialized emergency services programs for children and adults.

- The CSB developed and operates a crisis stabilization center for persons with mental illnesses and substance addictions. It was the first CSB-operated crisis stabilization program to accept TDOs.
- The ESP has an aggressive mobile outreach philosophy and practice; staff go out for most crises, day or night (in pairs or with police if need be).

Danville-Pittsylvania CSB
Jim Bebeau, LPC, Director of Mental Health Services
jbebeau@dpcs.org

- This CSB has a public/private partnership with a local hospital. The CSB places an ES clinician in the emergency room from 8PM to 12PM to provide extensive counseling and referral to next day CSB services or, if needed, purchase beds at the hospital. Since this agreement, the CSB has not had to send a consumer out of catchment area for inpatient care. The private hospital shares psychiatry time with the Southern Virginia Mental Health Institute, so that care is continuous if consumers transfer to the state facility.
- The CSB has an agreement with a private Assisted Living Facility to hold a bed free for urgent placements of consumers in crisis.
- The CSB holds a weekly meeting of case management, residential, emergency services, and psychiatrists to coordinate care of persons served or likely to be served by the ESP.

District 19 CSB
Rod Tsiptsis, Emergency Services Manager
804-541-6704
rtsiptsis@d19csb.com

- This CSB created a Strategic Planning and Monitoring Committee to coordinate care among programs and ESP, and to develop new program ideas.
- The CSB has four staff that are qualified pre-screeners on duty at the psychosocial rehabilitation program. This allows immediate crisis response for consumers and good coordination with the ESP.

Loudoun Co. CSB
Deborah Snyder, LCSW, Program Manager, MH/SA Emergency Services
703-771-5100
dsnyder@loudoun.gov

- This CSB has contracts with community agencies to provide emergency services at their sites: with private hospital for evaluations, with schools for behavior problems or to assess risk, at juvenile and adult detention centers for evaluations, with many agencies or groups for crisis incident debriefing, with the police for hostage negotiation.
- The CSB's residential support services program for persons with mental illness has a 24-hour on-call crisis capacity to help stabilize crises in the consumer's home.

Mt. Rogers CSB
Susan G. Austin, Director of Emergency Services

276-223-3234
susana@mrcsb.state.va.us

- This CSB has a model training program and training documentation system for new ESP staff.
- ESP workers are given a report each month with the names of consumers who have active crisis plans on file so ESP staff can access records or talk to program staff as crisis develops. This tool is most beneficial when adequate crisis service options such as stabilization centers are available.
- The CSBs mental retardation residential programs have developed crisis intervention and crisis stabilization capacities, offering augmented supports for consumers in crisis in their own homes or group homes. Medicaid waiver is the funding source.
- The CSB has access to a limited but effective emergency respite program for persons with mental retardation developed regionally with the Southwestern Mental Health Institute.
- The CSB has access to a 90-day intensive program developed regionally through partnerships with Southwestern Virginia Training Center, Southwest Virginia Mental Health Institute and six area CSBS. This program (Pathways) is designed specifically for individuals with a dual diagnosis of mental retardation and mental illness whose community placement is in jeopardy due to challenging behaviors.

New River Valley CSB
Cheri Warbuton, Coordinator of Access
540-961-8445
cwarburton@nrvcs.state.va.us

- The CSB has contracted with a local private general/psychiatric hospital to co-staff an office in the emergency room called "the Bridge" to provide a site to evaluate persons in crisis and facilitate their access to the hospital and other services.
- The CSB and the local Mental Health Association have co-sponsored a training program on mental health issues for police and sheriff departments from 14 jurisdictions. This is based on the well-known CIT program from Memphis, Tennessee.
- The CSB's residential support programs for persons with mental illness and mental retardation have developed crisis intervention and crisis stabilization capacities using Medicaid funding. They flex staff as needed and shore up programming when consumers are in crisis.
- The mental retardation programs make a case manager, specialized in emergency services, available to consult with ESP staff in crises involving consumers with mental retardation.
- The ESP area is in an especially well-designed, functional area, with good separation from other services and good safety for consumers and staff, including video monitoring of interview rooms.
- The CSB sponsors a hotline, "The RAFT," staffed by volunteers (mostly Virginia Tech students) from 4PM to 8AM. The hotline offers suicide prevention, crisis intervention and support, and refers emergency cases to the ESP staff.

Norfolk CSB
Jacqueline Schaede, Emergency Services Supervisor
757-664-7689
jacqueline.schaede@norfolk.gov

- The ESP has an aggressive mobile outreach philosophy and practice; staff go out for most crises, day or night, to the streets or consumers' homes. They have a close working relationship with city police, who call the ESP when they encounter a citizen in crisis and wait until CSB staff arrive, then stay with staff until evaluation/disposition is complete.
- The CSB and local hospital have developed an understanding and agreement that ESP must respond to community/police crises before seeing persons who are safely in the hospital if crises co-occur. This arrangement at least clarifies staffing limitations and reduces misunderstandings.
- CSB provides on-site ESP staff at all times.
- As a result of police-accompanied ESP outreach, this jurisdiction rarely uses ECOs.

Rappahannock Area CSB
Janine Rumberger, Emergency Services Coordinator
540-899-4338
jrumberger@racsb.state.va.us

- The CSB has created a crisis stabilization capacity in its residential service programs and at its psychosocial rehabilitation (clubhouse) program. When an enrolled consumer exhibits signs of crisis, the residences and the clubhouse have the capability to augment staffing and provide more intensive supports to help consumers weather crisis and prevent crisis escalation.
- One residence has reserved a bed for consumers in crisis and uses augmented staff to increase supports to consumers in crisis.

Richmond BHA
John P. Lindstrom, Ph.D., Director of Assessment, Emergency, and Medical Services
804-819-4195
lindstroj@rbha.org

- The ESP has an aggressive mobile outreach philosophy and practice. Staff go out for most crises, day or night, to the streets or consumers' homes. They have a close working relationship with city police, who accompany or meet the ESP when they evaluate a consumer in the community.
- CSB provides on-site ESP staff at all times.
- The CSB has qualified five pre-screeners at their two psychosocial rehabilitation programs, helping consumers by working with staff who know them, but are also qualified for emergency services provision.
- The two psychosocial rehabilitation programs share a nurse assigned as part of the staff. The nurse can monitor consumer's clinical status and provide medication including injections after consultation with CSB psychiatrists, greatly aiding the crisis prevention

and resolution capabilities of the CSB. The nurse also is able to assess and impact on the general physical health needs of consumers.
- The mental retardation service division of this CSB has three qualified pre-screeners and has hired an L.C.S.W. staff member who is qualified and interested in mental retardation. They intend to develop services for persons with mental retardation and mental illness, to include emergency services.
- Of 17 staff providing crisis services, all but 2 are licensed, and they are now eligible.
- The CSB has a generator system to assure electric service for phones and ESP operation during weather crises.

Valley CSB
William J. Thomas, Executive Director
540-213-7554
jthomas@vcsb.org

- This CSB has an excellent design for a separate ESP office. It features a separate entrance for persons in crisis, crisis waiting rooms, open bay office for staff communication, and private interview rooms with video monitoring for ESP staff to see consumers.
- The Medical Director of this CSB insists that he and his psychiatric colleagues be available to consult or see their own patients at any hour of the day.
- The ESP provides a copy of the overnight crisis log detailing all contacts for each CSB program manager the next morning, so they can know if the consumers they serve have had ESP contact.

Virginia Beach CSB
James Cornish, LPC, Supervisor of Emergency Services
757-437-6142
jcornish@vbgov.com

- The CSB has a program site (Magic Hollow) that offers intensive services for consumers. The ESP outposts a staff member to provide crisis intervention and crisis counseling at that high intensity site.
- The local police department uses non-uniformed warrants division officers to process ECOs and TDOs. Use of these officers during civil commitment procedures reduces the stigma associated with uniforms, weapons, and restraints.
- The CSB ESP conducts a quarterly consumer satisfaction survey about their services.
- The ESP reports a mobile outreach philosophy and practice; staff make case-by-case decisions, but predominately go out to consumer residences and the streets, day or night (with police if need be).
- The CSB is planning for ESP staff to have electronic access to current consumer records at all times with the introduction of new MIS.
- The CSB provides on-site ESP staffing at all times, with plans to enhance staffing for the busiest shifts.

Section V.E

CSB Emergency Services Budget Data

CSB Name	FY 04 - Total CSB Budget	FY 04 - Total ESP Expenditure	% of total CSB budget	Population	$ per person FY04-Total Budget/POP	$ per person FY04-Total ESP/POP
Alexandria	$ 23,843,519	$ 658,999	2.8%	134,100	$ 177.80	$ 4.91
Alleghany Highlands	$ 4,270,000	$ 191,519	4.5%	23,000	$ 185.65	$ 8.33
Arlington	$ 17,800,000	$ 454,874	2.6%	193,700	$ 91.89	$ 2.35
Blue Ridge	$ 21,340,310	$ 787,695	3.7%	241,400	$ 88.40	$ 3.26
Central Virginia	$ 21,370,426	$ 1,019,891	4.8%	230,100	$ 92.87	$ 4.43
Chesapeake	$ 12,027,727	$ 648,847	5.4%	206,600	$ 58.22	$ 3.14
Chesterfield	$ 22,260,000	$ 610,500	2.7%	275,400	$ 80.83	$ 2.22
Colonial	$ 10,324,286	$ 534,599	5.2%	137,700	$ 74.98	$ 3.88
Crossroads	$ 10,967,720	$ 305,642	2.8%	98,300	$ 111.57	$ 3.11
Cumberland Mountain	$ 15,300,000	$ 307,395	2.0%	98,700	$ 155.02	$ 3.11
Danville-Pittsylvania	$ 9,978,923	$ 439,513	4.4%	107,700	$ 92.65	$ 4.08
Dickenson	$ 2,071,004	$ 68,121	3.3%	16,200	$ 127.84	$ 4.21
District 19	$ 13,946,001	$ 816,801	5.9%	169,100	$ 82.47	$ 4.83
Eastern Shore	$ 6,580,000	$ 280,204	4.3%	51,500	$ 127.77	$ 5.44
Fairfax-Falls Church	$ 121,218,865	$ 3,375,422	2.8%	1,037,400	$ 116.85	$ 3.25
Goochland-Powhatan	$ 4,262,474	$ 192,680	4.5%	43,200	$ 98.67	$ 4.46
Hampton - NN	$ 38,775,955	$ 687,605	1.8%	324,900	$ 119.35	$ 2.12
Hanover	$ 8,038,217	$ 505,760	6.3%	92,800	$ 86.62	$ 5.45
Harrisonburg - Rock	$ 6,073,977	$ 260,078	4.3%	112,200	$ 54.14	$ 2.32
Henrico	$ 23,614,915	$ 1,927,439	8.2%	296,100	$ 79.75	$ 6.51
Highlands	$ 8,300,000	$ 420,680	5.1%	68,500	$ 121.17	$ 6.14
Loudoun	$ 19,707,629	$ 852,297	4.3%	224,500	$ 87.78	$ 3.80
Middle Peninsula - NN	$ 14,537,034	$ 587,436	4.0%	135,000	$ 107.68	$ 4.35
Mount Rogers	$ 23,007,820	$ 619,695	2.7%	119,700	$ 192.21	$ 5.18
New River Valley	$ 13,180,792	$ 483,854	3.7%	165,000	$ 79.88	$ 2.93
Norfolk	$ 18,108,159	$ 734,763	4.1%	233,900	$ 77.42	$ 3.14
Northwestern	$ 9,652,901	$ 659,961	6.8%	197,500	$ 48.88	$ 3.34
Piedmont	$ 11,675,874	$ 380,051	3.3%	138,700	$ 84.18	$ 2.74
PD 1	$ 9,134,138	$ 275,383	3.0%	93,100	$ 98.11	$ 2.96
Portsmouth	$ 9,119,478	$ 464,416	5.1%	97,900	$ 93.15	$ 4.74
Prince William	$ 20,736,982	$ 1,799,387	8.7%	377,900	$ 54.87	$ 4.76
Rappahannock	$ 15,086,723	$ 335,661	2.2%	279,100	$ 54.05	$ 1.20
RR	$ 10,410,000	$ 313,404	3.0%	145,200	$ 71.69	$ 2.16
Region Ten	$ 20,634,000	$ 443,407	2.1%	209,400	$ 98.54	$ 2.12
RBHA	$ 29,375,000	$ 1,189,120	4.0%	193,900	$ 151.50	$ 6.13
Rockbridge	$ 5,860,000	$ 277,480	4.7%	39,000	$ 150.26	$ 7.11

CSB Name	FY 04 - Total CSB Budget	FY 04 - Total ESP Expenditure	% of total CSB budget	Population	$ per person FY04-Total Budget/POP	$ per person FY04-Total ESP/POP
Southside	$ 7,719,564	$ 170,860	2.2%	87,000	$ 88.73	$ 1.96
Valley	$ 14,354,114	$ 474,590	3.3%	111,400	$ 128.85	$ 4.26
Virginia Beach	$ 32,447,109	$ 810,290	2.5%	428,200	$ 75.78	$ 1.89
Western Tidewater	$ 12,350,000	$ 651,342	5.3%	129,100	$ 95.66	$ 5.05
Average	$ 17,486,541	$ 650,442	3.7%	184,103	$ 99.35	$ 3.93
Total	$ 699,461,636	$ 26,017,661		7,364,100		

Discussion

Budget information for FY2004 was provided by each CSB in the questionnaire sent to all boards. According to this data, the total expenditures for all services for 2004 of all CSBs combined was over $699 million. This ranged from a low of just over $2 million to a high of over $121 million, with an average of $17.4 million. On this measure, the smallest CSB budget is only 1.6 per cent of the largest. Obviously, the size of the communities served is a major component of budget size, and the two CSBs at the poles of this analysis are indeed the largest and smallest CSBs by size of population. A review of expenditures per capita reveals different distributions. The lowest expenditure per capita was $48.88; the highest was $192.21, involving two predominately rural CSBs.

Expenditures for emergency services were also analyzed. Expenditures ranged from a low of $68,000 to over $3.3 million, once again by the smallest and largest CSBs, respectively. The mean was $650,000. What portion of a CSB's total expenditure is for emergency services? Charting the percentage of emergency services expenditures of the total expenditure for each CSB yielded poles of 1.8 per cent at the lowest to 8.7 per cent at the highest – both large urban CSBs. Finally, emergency services expenditures per capita were analyzed. Expenditures per capita ranged from a low of $1.20 to a high of $8.33, with a mean of $3.93.

Section V.F.1

Office of the Inspector General

Survey of Emergency Services
Virginia Community Services Boards

Name of CSB _____

Contact Person _____
Title _____
Telephone _____
Email Address _____

OIG Interviewer _____
Date of Interview _____

Access and Responsiveness of Emergency Services Program (ESP)

1. Is access to your emergency services through the same telephone number regardless of location, time of day, or jurisdiction in your CSB's catchment area?

yes___ no___ If **yes**, what is that telephone number? ( )_____-_____

2. Where are these telephone numbers published or otherwise made known to persons who may need them? please check all that apply, and add others:

____	Telephone book yellow pages	____	CSB recorded answer device
____	CSB brochure	____	Radio or TV announcements
____	CSB web site	____	_____
____	Posters at community sites	____	_____
____	Appointment cards	____	_____
____	Employee business cards	____	_____

3. Is a toll free number available for calls to your CSB from all jurisdictions you serve? yes _____no_____

4. Do you have capacity to handle language translation needs and TDY access at the initial call by a person in crisis?

During ESP office hours yes _____ no _____ If **yes**, what do you do?_____
During nights and weekends yes _____ no _____ If **yes**, what do you do?
_____

If **no at any time**, what do you do to afford access to the caller?
_____

5. Who answers the phone and what are the steps needed to reach an emergency services clinician (e.g., CSB receptionist, answering service, 911 center, direct call to on-call CSB staff)? Please note if the initial response is a recording.
(Examples: "The CSB receptionist takes the call and transfers it to the ES office, where a clinician answers," or "An answering service with a live operator takes the call and beeps an on-call ESP clinician, perhaps at his or her home, who then calls the answering service, and then calls the caller back."

Weekdays _____
_____
_____

Evenings, nights, weekends _____
_____
_____

Are there any variations among the jurisdictions you serve? Please describe:
_____
_____

6. Do you have a standard for response time (time allowed) for a consumer to reach a clinician?
No _____Yes ____ If yes, what is the measure (time allowed) to

reach a clinician by phone? _____
meet face-to-face with a clinician _____

Do these standards vary for evenings, nights, and weekends? If so, please explain
_____

Do you collect and monitor data on response time? _____
If yes, what is your most recent performance on relevant variables?
_____

7. What is the total number of FTEs assigned in FY04 to your emergency services program? _____. How many people does this include? ____

8. Please list the staff you employ in ES (full and part time, on-call: anyone who may provide ES services) and their qualifications:

Employee number or initials	Degree	License LCSW, LPC, CNS	years of clinical experience	years of ES clinical experience	hours per week on ES

Extend table or add another sheet if more space is needed

Do you employ any consumers as peer support specialists on your ESP? yes___no____

9. Do you have 24 hour on-site ESP staff? Yes _____ No _____

10. How do ESP staff determine if a crisis caller is currently or recently served by the CSB? Please indicate which applies:

	Can physically or electronically access case management or other main record, including medications.	Can physically or electronically access only whether a consumer is currently served by the CSB.	Cannot independently ascertain whether a consumer is currently served by the CSB.
Weekday office hours – from the CSB ESP office			
Nights and weekends – from the off site ESP on call staff			

11. Do CSB program staff (e.g., residential, case management) alert the ES program of impending or likely crises with currently served persons so that a coordinated plan of contingent care can be developed?

Rarely done_____ Sometimes done _____ Always done _____

12. How and by when do ES staff communicate crisis events back to CSB program staff? Always done within 24 hours, by policy _____ No policy, happens occasionally ___ Rarely happens _____

13. What crisis intervention or emergency services (other than mandated ECO and TDO prescreening) does your CSB offer? "Offer" means a regular, repeating, consistently available service, not an occasional occurrence. Check those that are available, comment or expand as needed in the space provided below:

Crisis Intervention Services Continuum	Weekdays, ("office hours")	Nights and weekends ("after office hours")	Variations among localities? e.g., central clinic only, please comment
Hotline operated by CSB (may be with volunteers, but CSB supervised and sponsored)			
Telephone crisis contact with CSB clinician (**brief**) Usually information and referral, information exchange			
Telephone crisis counseling with CSB clinician (**extended**) therapeutic intent, an effort to defuse crisis, provide crisis intervention			
Face-to-face crisis counseling with CSB ES clinician – **immediate** without ECO or prescreening requirement			
Face-to-face crisis counseling with CSB ES clinician – **guaranteed next day** (not mere referral for possible outpatient appointment)			
Off site or **mobile outreach face-to-face** with CSB ES clinician(s). e.g., at consumer's home, on the streets, etc.			
Crisis consultation (telephone – routine, by policy, not occasional exceptions) **with CSB program staff (e.g., residential)** about existing CSB consumer			
Crisis consultation with psychiatrist (med consult, call in prescription, etc. – routine, by policy, not occasional exception)			
Face-to-face crisis psychiatric evaluation and medication administration (M.D sees consumer, prescribes or administers meds, 24 hours).			
CSB has a partnership with **consumer-run residential support** or safe house program			
24 hour CSB-operated residential support service (in the consumer's home varying supports as needed)			

24 hour CSB-operated voluntary crisis stabilization service (includes nursing on site and M.D. availability, e.g. consultation, daily visit)			
24 hour CSB crisis stabilization (TDO) facility, (nursing on site, M.D. daily, on site or call for assessments and interventions), accepts TDOs			
CSB-operated inpatient facility – CSB controls, operates admission, treatment, discharge			
Local, contracted **CSB bed purchase** of acute inpatient services; CSB exerts some control of admission, discharge, and treatment coordination			
Social detox program for substance use disorders			
Medical detox program for substance use disorders			
other			

Comments:

16. **Service use data**. Please provide the following information **for March 2005**. These items will not be mutually exclusive or discrete. Generally, the data should step down in numbers

If data about age is not available, please estimate based on context of contact

	Adults 18-64	Children under 18	Aged over 65
Number crisis telephone contacts*			
Number of face-to-face crisis contacts*			
Number of ECO evaluations*			
• Number of ECOs released by clinical judgment			
• Number of ECOs released- expired (e.g., no bed)			
• Number of ECOs detained on TDO			
Number TDOs committed*			

*may be duplicated count (consumers seen more than once in the month)
includes parental consent or adults voluntarily admitting at hearing

17. Of the total crisis contacts above, for March 2005, approximately how many were

primary mental retardation issues _____
primary substance abuse issues _____
forensic issues, e.g. jail transfers _____

18. Please provide (by electronic version if possible) the following documents, if they are available:

	Available?
ESP program description	_____
ESP operating procedures	_____
Total CSB budget FY04	_____
Total ESP expenditure FY04	_____
Total ESP revenue FY04	_____
Local	_____
State	_____
Fee	_____
Other	_____

Section V.F.2

ESP and CSB Staff Interview

CSB _____
Date_____
OIG Staff _____

Staff member: (check one)	Executive Director or Clinical Services Director	_____
	Emergency Services Director or supervisor	_____
	Emergency Services staff member	_____
	Director of MR	_____
	Director of SA	_____
	Director of Child	_____
	CSB program director (Community Support, psychosocial, residential, case management)	_____

1. How long have you worked for the CSB_____? For the ESP* _____? What is your highest degree?_____ Are you licensed? (note license) _____

2. What is the mission that guides the Emergency Services Program of CSB? Is there a mission statement for the agency? For ESP?

3. Name three values or principles that have been established (or adopted) by the CSB to guide the work of the ESP - how you are to carry out your work.

4. Are there ways in which you can contribute your ideas to your CSB's planning and decision making with regard to policies, procedures, programming related to ES? Please name the ways.

5. Do you feel valued by your organization If yes, what are the things that make you feel valued? If no, why not?

6 If you have ideas about the care of a specific consumer (including care in residential, day support, etc.), are there ways for you to share your ideas and are your ideas accepted?

7. Do you think consumers are protected and safe when served by the ESP? If yes, what steps are take at the CSB to assure this? If no, why not?

8. There is a new approach being taken across the country in the treatment of individuals with mental illness. It is called "recovery." Have you heard any talk around this CSB about the "recovery principles?" Have you received any training on these principles?

9. How often do you have contact about Emergency Services with the Executive Director and other members of the leadership team, such as the clinical/mental health division director, director of MR, Child, etc.?*

10 Does your ESP have written policies and procedures for how you should provide ESP services?* Do you use it and know its requirements?

11. What does your CSB do to assure that you have the knowledge, skills, and abilities to provide these services? Describe your training program. Are you tested for competence?

12. What are your qualifications to provide the following specialized emergency services? What does your CSB do to help qualify you for these areas?*

- Child needs, services, and code requirements

- Mental retardation issues and services

- Substance use disorder issues

13. Does a supervisor go over your prescreening forms and decisions with you?*

14. When you are on duty after office hours for ESP, what access do you have to a supervisor for consultation or guidance?

- Are there any decisions that you make that you are required to seek the concurrence of a supervisor?

- Can you call upon a psychiatrist for emergency consultation?

- At any hour?*

15. What are the three biggest problems you face in meeting the crisis intervention needs of the consumers you see?

16. What is the ability of CSB program sites (e.g. residential, case management), other than using Emergency Services, to handle crises?

17. If you see a consumer in crisis after office hours, can you tell if he/she is already being served by the CSB and access details of current treatment history?

18. Do you routinely ask a consumer in crisis if they have a plan that states their preferences in case of emergencies?" Does your CSB work with consumers to develop such plans?

19. Please share with us what emergency services your CSB offers (crisis services other than crisis pre-screening, e.g., crisis stabilization services).

20. What one service, if your CSB had it, would help in resolving crises more satisfactorily for the consumer and other stakeholders?

* These questions are for ESP staff only.

Section V.F.3

ESP Stakeholder Interview

CSB _____
Date_____
Stakeholder (Name and Role)_____
OIG Staff _____

1. Do you think the staff of the CSB's ESP are qualified for their jobs? (both clinical capabilities and knowledge of the code)

2. When you (or citizens) need to reach the ESP,

   - do people know how to do it?

   - Is it convenient and accessible? Have you had any problems trying to reach the ESP?

   - Are you satisfied with how the phones are answered and how you are transferred?

3. Is the ESP responsive to your call? How long do you have to wait to talk to a clinician?

4. How long does it take from the first call to the ESP sitting down, face to face with a consumer?

5. Has anyone from the ESP ever asked your opinion on how well they met your needs or how they could improve service to you? Is there a regular structure or process for providing input and quality improvement?

6. How well do you have your crisis (or your community's) needs met by the ESP? Do you get what you need or what you think consumers need?

7. What other emergency services do you wish your CSB offered to help with psychiatric crises (eg., crisis stabilization center) to avoid hospitalization?

8. What is your biggest complaint about the service the CSB provides?

9. What is your biggest appreciation about the service the CSB provides?

10. If you could change one thing about Virginia's approach to crisis intervention, what would it be?

Section V.F.4

Emergency services program Consumer Input Survey

From the Virginia Office of the Inspector General for Mental Health

This is a survey for any person in Virginia who has used emergency services from any local Community Services Board. It comes from the Office of the Inspector General, which is conducting statewide quality inspections of emergency services that CSB's offer.

You can help by completing this survey about your own experiences with emergency services and returning to the Office of the Inspector General by July 15. We would like to get as many responses as possible.

YOUR REPLY WILL BE KEPT COMPLETELY CONFIDENTIAL by the Office of the Inspector General and will not be given to anyone or any other agency.

Please encourage other consumers to complete this survey.

If you complete this survey, please send it to:
Heather Glissman, Office of the Inspector General, P.O. Box 1797, Richmond, VA 23218-1797
Fax 804-786-3400 email: heather.glissman@oig.virginia.gov

If you have any questions or wish to be contacted, call or email John Pezzoli, Senior Inspector/Project Manager, Office of the Inspector General (804) 692-0419 or john.pezzoli@oig.virginia.gov

Have you had experience with this CSB's emergency services system within the last five years? Yes No

Note: CSB = Community Services Board

1. Do you think the staff of your CSB's emergency services program are qualified for their jobs?

2. How welcoming, supportive, and comforting are the staff? Please explain:

3. Is it convenient and accessible for you to reach emergency services? Are you satisfied with how the phones are answered and how you are transferred? _____ If no, please describe how it could be more convenient and accessible or how the process could be improved:

4.. Is the emergency services program responsive to your call? How long did you have to wait to speak to a clinician?

5. If you needed to see a clinician in person, how long did it take from your first call to sitting down with a clinician face to face?

6. Has anyone from your emergency services program ever asked your opinion on how well they met your needs or how they could improve service to you?

7. How well did you have your crisis needs met by the emergency services program? Did you get what you needed?

8. Did the emergency services program staff ask you about your

Strengths and resources? _____

Choices and preferences? _____

Whether you had an advance directive or plan for what do to in case you have a crisis? _____

Whether you wanted to notify friends or families about your whereabouts? _____

9. Did you feel safe when served by the emergency services program? Do you feel they looked after your safety?

10. Where were you seen by the emergency services program clinician?

_____ At the CSB

_____ At a local hospital

_____ At a jail

_____ At a residence

_____ Other, please specify: _____

11. How comfortable, welcoming, private, and supportive is that site (see question #13)?

12. What services do you wish your CSB offered to help you during a crisis?

13. What is your biggest complaint about the service you received from your emergency services program?

14. What is your biggest appreciation about the service you received from your emergency services program?

15. Were you ever held on an Emergency Custody Order (ECO)? Tell us how you felt about that experience.

16. Were you transported by a sheriff or police officer? Tell us about that experience.

17. If your emergency services visit led to hospitalization, can you tell us what would have made it possible for you to stay in the community instead of going to the hospital?

18. Is use of civil commitment and hospitalization the last resort of your emergency services program, or do you feel they turn to that option too quickly?

Section V.F.5

Emergency Services Program - Family Input Survey

From the Virginia Office of the Inspector General for Mental Health

This is a survey for family members of persons who have used, or have had a family member use emergency services from any local Community Services Board (CSB). It comes from the Office of the Inspector General (OIG), which is conducting statewide quality inspections of emergency services that CSB's offer. Other surveys are going to CSB staff, consumers, other stakeholders such as sheriff's and private hospitals, plus the OIG is conducting unannounced inspections of a large sample of CSBs.

You can help by completing this survey about your own experiences with emergency services and returning to the Office of the Inspector General by June 20. If the survey seems too long for you, you may just answer the questions that you think cover your main concerns.

YOUR REPLY WILL BE COMPLETELY CONFIDENTIAL to the Office of the Inspector General and will not be given to anyone or any other agency. The OIG report of the study will be systemic (taking into account all CSBs), and reports will not be issued for each specific CSB.

Please encourage other family members to complete this survey. Distribute it as you wish.

When you complete this survey, please send it to(by email, fax, or US Postal service):

Heather Glissman, Office of the Inspector General, P.O. Box 1797, Richmond, VA 23218-1797
Fax 804-786-3400 email: heather.glissman@oig.virginia.gov

If you have any questions or wish to be contacted, call or email John Pezzoli, Senior Inspector/Project Manager, Office of the Inspector General (804) 692-0419 or john.pezzoli@oig.virginia.gov

Date:

Community Services Board that is the subject of your comments (required):

Have you or a consumer family member had experience with this CSB's emergency services system within the last five years? Yes No

1. What do you think is the mission or purpose of your CSB's emergency services program (ESP)?

2. What values or principles do you think guide your CSB's emergency services program?

3. Do you think the staff of your CSB's emergency services program are qualified for their jobs? Please explain:

4. How welcoming, supportive, and comforting are the staff? To your family member? To you? Please explain:

5. Is the ESP convenient and accessible for you? Are you satisfied with how the phones are answered and how you are transferred? _____ If no, please describe how it could be more convenient and accessible or how the process could be improved:

6. Is the emergency services program responsive to your call? How long did you (or your consumer family member) have to wait to speak to a clinician?

7. If your family member needed to see a clinician in person, how long did it take from your first call to your consumer family member sitting down with a clinician face to face?

8. Has anyone from your emergency services program ever asked your opinion on how well they met your needs or how they could improve service to you?

9. How well did you have your crisis needs met by the emergency services program? Did your family member get what he/she needed? Did you as a family member get what you needed?

10. Did the emergency services program staff ask you about your consumer family member's:

    Strengths and resources? _____

Choices and preferences? _____

Whether you and the consumer had an advance directive or plan for what do to in case of a crisis? _____

Whether the consumer wanted to notify friends or families about your whereabouts? _____

11. Did you feel safe when your consumer family member was served by the emergency services program? Do you feel they looked after his or her's safety?

12. Where was your consumer family member seen by the emergency services program clinician?

_____ At the CSB

_____ At a local hospital

_____ At a jail

_____ At a residence

_____ Other, please specify: _____

13. How comfortable, welcoming, private, and supportive is that site (see question #13)?

What would you change about it?

14. What services do you wish your CSB offered to help you and your consumer family member during a crisis?

16. What is your biggest complaint about the service you received from your emergency services program?

17. What is your biggest appreciation about the service you received from your emergency services program?

18. Was your consumer family member ever held on an Emergency Custody Order (ECO)? Tell us how you felt about that experience.

19. Was he or her transported by a sheriff or police officer? Tell us about that experience.

20. If your consumer family member's emergency services visit led to hospitalization, can you tell us what would have made it possible for him or her to stay in the community instead of going to the hospital?

21. Is use of civil commitment and hospitalization the last resort of your emergency services program, or do you feel they turn to that option too quickly?

Section V.F.6

ESP Site Observation Checklist

CSB _____
Date_____
OIG Staff _____

1. Where is the main (day time, weekdays) CSB ESP site?

   CSB office _____
   Other site (identify)-
_____
_____

2. Is the main ESP site visually and audibly relatively separate from main CSB operations (e.g. outpatient services, intake, waiting rooms, etc.), so that persons in crisis are afforded adequate privacy?

3. Is the main ESP site comfortable and pleasant in appearance?

4. Does the main ESP site afford safety for the consumer and staff?

5. Are law enforcement officers or vehicles visible to the visiting public and other consumers during crisis evaluations at the main ESP site?

6 Where are crisis intervention services provided (secondary crisis intervention sites)

   Evenings (5PM-8PM) _____

   Nights and weekends _____

7. Observations of the secondary crisis intervention sites.

Section V.F.7

OFFICE OF THE INSPECTOR GENERAL
Clinical Record Review

CSB Emergency Services

CSB: _____

OIG Staff: _____

Record ID: _____

CSB staff ID: _____

Location of crisis service: _____

Element	**Met/Not Met or Yes/No**	**Comment**
Documentation is legible		
Clinician documented the presenting problem clearly and succinctly from consumer's perspective from perspective of others		
The consumer was asked what services he/she desired to resolve the crisis		

The clinician asked the consumer if he/she has an advance directive or any other contingency plans such as a "route map"		
The clinician performed a comprehensive assessment of risk.. to the consumer to others		
The competence of the consumer to make choices was assessed		
The consumer was offered choices of less restrictive alternatives		
The consumer was asked about strengths, supports, and resources that might resolve the crisis		
With the consumer's permission, information was sought or shared with relevant others in the community		
Assessment of substance use documented		
Consultation with CSB program sought and documented.		
Clinical supervision was sought and documented.		
Psychiatric consultation was sought and documented.		
Consumer was detained on an ECO		

Consumer was released from ECO on clinically appropriate grounds		
Consumer was recommended to be detained on TDO, if yes note time and issues encountered in finding a bed		
if yes, TDO criteria was met and supported with objective and validated subjective observations a. danger to self – variables identified b. danger to others – variables identified c. inability to care for self – variables identified		
If yes and TDO was issued, was consumer involuntarily admitted? (committed)		
Need for medical clearance assessed		
If needed, medical clearance secured, describe how and how long it took		
Clinician provided hospital with treatment recommendations and preliminary discharge planning ideas		
Crisis contact is communicated to CSB program (or planned to be)		

Section V.F.8

Mental Health Facility Survey of CSB Emergency Services Program (ESP)

Name of Facility:

Facility Contact:

Name of CSB:

1. What do you think is the mission or purpose of the CSB ESP?

2. What values or principles do you think guide the CSB ESP?

3. Do you think the CSB ESP staff have the knowledge, skills and abilities for their jobs?

4. Are the prescreens from this CSB, legible, clinically pertinent and thorough?

5. Is there evidence in the prescreen documentation that hospitalization is the least restrictive alternative?

6. Does the prescreening documentation from the CSB provide information that addresses and assists in discharge planning?

7. Has medical clearance been adequately addressed by the CSB?

8. Has anyone from the ESP ever asked your opinion on how well they met your needs or how they could improve service to you? Is there a regular structure or process for providing input and quality improvement?

9. What services do you wish your CSB offered to help with psychiatric crises?

10. What is your biggest complaint about the service the CSB provides?

11. What is your biggest appreciation about the service the CSB provides?

12. If you could change one thing about Virginia's approach to crisis intervention, what would it be?

Section V.F.9

40 CSB Response Time Survey

(2 calls for each CSB – 1 during office hours/1 after hours -- All calls to be made within the area code of the CSB using the Emergency services #'s that the CSB provides in the survey)

CSB:

OIG Staff:

Date:

Dialed:

Toll Free #:

Source of Phone #:

Time call was dialed **(interviewer start stopwatch – STOP ONLY WHEN REACH ES CLINICIAN):**

Number of rings to answer:

Was phone answered "live or automated or provides an additional phone number to call"?

1. **If answered "live"** – clarify if they are an ES Clinician. If yes, note time:
   If no, request a worker and note next steps.

2. **If automated,** was access to crisis option: clear, simple and rapid?
   Next Steps?
   Note time when ES worker is contacted:

Total elapsed time from first dial to voice contact with ES clinician: